

# Health Savings Account (HSA) Claim Form



Employer: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Social Security Number \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Check Here if New  
Address

Daytime Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Check Here if Employed  Date of Termination: \_\_\_\_\_

## ▶ HOW TO FILE A CLAIM:

1. Complete form listing expenses for spouse or dependents either enrolled or not enrolled in your HSA plan. If individuals are not enrolled in your HSA plan, but enrolled in another health plan, expenses related to accident, disability, dental, vision or long-term care insurance are tax-free. Other expenses such as drug or office visit copayments may not qualify for tax-free treatment, but will be reimbursed to you. You are obligated to report any non-qualified requirements to the IRS. Review your Employee Summary for additional information. Attach extra Claim forms if needed. SIGN and DATE below.
2. Keep all original documents for your records.
3. Fax or Mail to HealthSCOPE Benefits at 877-240-0135 or P. O. Box 3627, Little Rock, AR 72203

**DOCUMENTS MUST BE LEGIBLE**

Name	Date of Service	Identify (Self, Child, Spouse)	Enrolled in your HDHP? Yes/No	Describe Expenses (Medical Check-up, Dental, Vision)	Amount Claimed

**TOTAL \$** \_\_\_\_\_

## ▶ Account Holder Authorization

\_\_\_\_\_  
Signature of Account Holder

\_\_\_\_\_  
Date

Account Holder acknowledges responsibility under this HSA for payment to service providers.  
In addition, expenses claimed will not be sought from another Plan or taken as deductions on my tax return.

www.healthscopebenefits.com . 1-888-763-8232 . Fax 1-877-240-0135

