Health Savings Account (HSA) Claim Form

NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

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

HealthSCOPE BENEFITS