Health Reimbursement Account
CLAIM FORM

NAME:	Last First MI	**EMAIL**	
ADDRESS	Street City State ZIP	**PHONE**	( )

☐ **Please check if this is a new address**

Please attach a copy of the applicable Select Health Explanation of Benefits with this form.

* Information below must be completed

Deductible Expense CLAIMS

Date of Service MM/DD/YY	Patient Name	Relationship	Name of Provider	Description of Service	Claim Amount
					$
					$
					$
					$
					$
				Total:	$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, including flexible spending, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ Date: _____ /_____ /_____

FOR FASTEST REIMBURSEMENT, FAX TO (435) 725-6199 OR EMAIL TO CLAIMS@CBSESERVICES.COM

OR MAIL TO: CUSTOM BENEFIT SOLUTIONS
244 WEST HWY 40 (333-8), ROOSEVELT, UT 84066

FOR QUESTIONS PLEASE CALL 866-656-0227

Single	Two Party	Family
Eligible for up to $500 after the individual $500 deductible has been satisfied.	Eligible for up to $500 after the individual $500 deductible has been satisfied. Eligible for an additional $500 after the family $1000 deductible has been satisfied.	Eligible for up to $500 after the individual $500 deductible has been satisfied. Eligible for an additional $500 after the family $1000 deductible has been satisfied.