CLAIM FORM

Reimbursement of Payment Request

Employer Name

_____

Employee Information

_____
Name (Last, First, Middle Initial)

_____
Social Security Number **(Last Four Numbers are Required)**

_____
Address (Street)

_____
Address (City, State, Zip) ☐ **Check Here If New Address**

_____
Employee Email Address

Names of Dependents

(For whom expenses are currently being submitted.)

Dependent Name	DOB	Relationship

I hereby certify that the information on this claim form is correct and authorize release of payment through my reimbursement account. I understand that reimbursement is not a guarantee that this payment is tax exempt. I have not received and will not receive reimbursement for these expenses from this or any other plan. The total of reimbursed dependent care expenses for the plan year does not exceed my or my spouse's earned income (W-2 pay) for the year. I understand that reimbursed dependent care expenses cannot be used to claim a credit on my personal income tax return.

_____ _____
Employee Signature Date

Where To Send a Claim:

nyhart
www.nyhart.com

Mail: Nyhart
Claim Reimbursement
8415 Allison Pointe Boulevard, Suite 300
Indianapolis, IN 46250-4159

Email: support@nyhart.com

Fax: 1-888-887-9961

Phone: 1-800-284-8412
317-845-FLEX (3539)

Expenses to be Reimbursed

☐ Health Care

*Expenses must be ineligible or non-reimbursed by medical/dental plan.
*The service must be provided while participating in the plan.
*The claim must be submitted during the claim eligibility period.

Type of Expense	Date Incurred	Amount
Medical		
		$
		$
		$
		$
	Total	$ 0
Dental		
		$
		$
		$
		$
	Total	$ 0
Vision		
		$
		$
		$
		$
	Total	$ 0
Other		
		$
		$
		$
		$
	Total	$ 0

☐ Dependent (Child) Care

*Expenses must be considered to be for the care of the child.
*Expenses may not be used to claim a credit on personal income taxes.
*The claim must be submitted during the claim eligibility period.

		$
		$
		$
		$
	Total	$ 0

Dependent Care Provider

_____
Name

_____
Address

_____
Tax ID Number or SSN for Individuals

nyhart
www.nyhart.com

Instructions for Filing a Claim

- For medical/dental/vision expense claims that were submitted to a health plan or an insurance company but were not fully paid by that carrier, **please attach copies of the insurance carrier claim and/or payment form such as an Explanation of Benefits (EOB)** to establish the amount not covered under the medical/dental/vision plan.
- For all other reimbursable expenses, the copies of all itemized bills must be attached. **These must list name and address of the service provider, the date(s) of service, the service provided, and the patient responsibility.**
- Please be aware canceled checks alone are not acceptable receipts.
- For all dependent care expense, the copies of paid receipts must be attached. **These must include the name and address of the service provider, the date(s) of service, the service provider, and fee for the service.**
- PLEASE DO NOT HIGHLIGHT receipts.
- **The Claim Form must be complete, including Participant signature and date.**
- **Please keep original documents for your records and send Nyhart the copies.**