FSA Debit Card Substantiation Form

NAME:	Last First	SS#	
ADDRESS:	Street City State ZIP	PHONE:	( )

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

* Information below must be completed

DEBIT CARD EXPENSE

Transaction Date	Patient Name	Relationship	Name of Merchant	Description of Service	Debit Card 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, 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 801.561.5056 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