HSA Qualified Expense Log & Claim Form

Account Holder _____ **SS#** _____
Last First

Use this form to report eligible expenses incurred. You may request a distribution from your Health Savings Account or retain qualified expenses in inventory.

For prompt service please make sure to:

1) complete this form;
2) attach copies of *itemized* bills that indicate patient's name, service date (must be on or after date account opened), provider, service (include drug name or NDC# for Rx), expense amount.
Please note: cancelled checks and credit card receipts alone are not sufficient;
3) attach copies of "Explanation of Benefits" from benefit plans covering these services and expenses;
4) indicate whether claim is for inventory or reimbursement; sign and date the Claim Form.

Patient Name	Date of Service	Provider	Type of Service	Amount

		Total submitted →	
Distribution Requested	☐	Less total reimbursement requested →	
Retain in Inventory	☐	Amount to retain in inventory →	

Account Holder Certification:
I certify that the expense(s) listed above were incurred by me or my eligible dependent and qualify for reimbursement, that reimbursement is not available from any other benefit plan and that I have not received any reimbursement from other sources for these expenses. I understand that all reimbursement received from my HSA will be paid directly to me and that I am responsible for any taxes or penalties that may arise in the event that I request and receive reimbursement that does not qualify for tax deductibility under federal or state law.

Authorized Signature _____ Date _____

Mail to: Frates Benefit Administrators
P. O. Box 269001
Oklahoma City, OK 73126-9001

or **FAX to:** (405)- 557-5592
Attention HSA Claims

Frates Benefit Administrators

HSA