CHOICE CARE CARD

Did you know you can submit claims online? Visit www.choicecarecard.com to submit claims through your online account.

Claim Form

Please complete, sign and date this claim form. Attach all the appropriate documentation. Your plan is governed by IRS guidelines. In order to satisfy IRS requirements certain documentation is needed to process claims. Lack of the employee's social security number, missing information and/or insufficient documentation will delay the processing of your claim.

PART A	CLAIMANT DATA		(please print)
COMPANY NAME:			
EMPLOYEE'S LAST NAME	**EMPLOYEE'S FIRST NAME**	**MI**	Employee's Social Security
☐Check here if this is an address change	**Employee's Mailing Address** (Street or PO BOX)		Apt. #
City		State	Zip

How should we contact you with questions regarding your claim?

☐ Phone:	☐ Fax:
☐ Email:	☐ U.S. Mail:

PART B EXPENSES TO BE REIMBURSED (please print)

Name of provider and description of expenses	Date	Amount to be reimbursed
		Total: $

***IMPORTANT: PLEASE READ THE FOLLOWING…**

Do not include amounts paid or eligible for payments under any other health care plan or program, federal, state, or government program, workers' compensation or any other policy of health insurance. All checks and direct deposits will be issued to the enrollee, not to providers or dependents. You will only be reimbursed for the amount totaled above.

PART C CLAIM SUBMISSION

Please email, mail or fax your claim to:
The Choice Care Card | 76 McNeil Road | 2nd Floor | Waterbury Ctr, VT 05677 | Fax 1-802-244-2020 | claims@choicecarecard.com

PART D EMPLOYEE'S STATEMENT

I hereby certify that the information contained in Part B, Expenses to be Reimbursed, is true and correct to the best of my knowledge and belief. I understand that I am responsible for providing proof to support each claim expense submitted for reimbursement. Any reimbursed expense later discovered to be ineligible for reimbursement will be taxable to me. In addition, I understand that Dependent Care expenses paid with pre-tax dollars cannot be claimed on my income tax return.

Employee Signature: _____ **Date:** _____

Direct Deposit (ACH): When filing claims manually, I hereby authorize The Choice Care Card to Credit the account indicated below:

Account Number: _____ Transit Routing Number (9 digits): _____

Type of Account: ☐Checking ☐Savings