HCID-02

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HEALTH CARE FLEXIBLE SPENDING ACCOUNT CLAIM REIMBURSEMENT FORM

How To Prepare Your Claim Form

Step 1 Complete all employee information. This form will be processed electronically. Print clearly and only in the spaces provided.
Step 2 Complete expense information. For the Service recipient, please provide the name of the person who received the product or service.
Step 3 Sign and date the claim form and attach copies of proof of expenses. Bills, statements, or "Explanation of Benefits" (EOBS) from medical plan(s) are required proof of expense(s). Canceled checks are not sufficient evidence as proof of expense.
IMPORTANT! DO NOT combine multiple expenses on a single line. List each expense separately. Whether submitting single or multiple claims via fax, always send the claim form followed by its supporting documentation or receipts. If mailing the form, only send copies of the supporting documentation or receipts and retain the original(s) for your records. DO NOT include fax cover sheet when faxing your reimbursement request.

Employee Information

(PLEASE PRINT)

Name

Employer Name **Enterprise Holdings**

Address

Email Address

(By providing your email address, you will receive electronic notifications)

City State Zip Daytime Phone #

Alternate ID

5 7 0 0

Instructions: Please use blue or black ink and print like this → 0 1 2 3 4 5 6 7 8 9

Expense Information

Start Date of Service			NOTE: Please report only one expense per block. Combining multiple expenses in one block may result in a delayed reimbursement.	Amount	
MONTH	DAY	YEAR		DOLLARS	CENTS
			1 NAME OF PROVIDER TYPE OF SERVICE: HEALTH ☐ DENTAL ☐ OTC MEDICAL SUPPLIES ☐ VISION ☐ PRESCRIPTION ☐ OTC MEDICINE/DRUG ☆ ☐ SERVICE RECIPIENT NAME		
			2 NAME OF PROVIDER TYPE OF SERVICE: HEALTH ☐ DENTAL ☐ OTC MEDICAL SUPPLIES ☐ VISION ☐ PRESCRIPTION ☐ OTC MEDICINE/DRUG ☆ ☐ SERVICE RECIPIENT NAME		
			3 NAME OF PROVIDER TYPE OF SERVICE: HEALTH ☐ DENTAL ☐ OTC MEDICAL SUPPLIES ☐ VISION ☐ PRESCRIPTION ☐ OTC MEDICINE/DRUG ☆ ☐ SERVICE RECIPIENT NAME		
			4 NAME OF PROVIDER TYPE OF SERVICE: HEALTH ☐ DENTAL ☐ OTC MEDICAL SUPPLIES ☐ VISION ☐ PRESCRIPTION ☐ OTC MEDICINE/DRUG ☆ ☐ SERVICE RECIPIENT NAME		
			☆ If OTC MEDICINE/DRUG (Over-The-Counter Medicines/Drugs) is selected, then you must submit a receipt with an RX number or a copy of a doctor's prescription if it is not already on file. Please review visit www.flexdirect.adp.com/erac/ for more information.		

To Submit Your Claim:
Fax to: (866) 392-4090 (Toll-free) or (678) 762-5900 (Do Not Attach Fax Cover Sheet)
Or mail to: ADP Claims Processing, P.O. Box 1853, Alpharetta, GA 30023-1853
Questions and information: Call (800) 550-0720 or visit www.flexdirect.adp.com/erac/

Total Expenses → $

Certification

I certify that the expenses listed above qualify for reimbursement and have been incurred by me or by eligible members of my family. These expenses have not been reimbursed by my heath care plan or any other health care plan, such as my spouse's. Additionally, these expenses are not being claimed as tax deductions under Section 213 of the IRS code. Bills, statements, or other proof of the expenses are attached.

SIGNATURE _____ DATE _____