COMMUTER FLEXIBLE BENEFIT PROGRAM

Reimbursement of Payment Request

nyhart

Employer Name

Social Security Number

Name (Last, First, Middle Initial)

Email Address

Address (Street)

Phone Number

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

I hereby request reimbursement for the following expenses:

DATE OF PURCHASE (mm/dd/yy)	NAME OF PROVIDER	DESCRIPTION	AMOUNT
		Total Amount for Transportation or Parking Expense Reimbursement	0

Read Carefully: Please attach a copy of all supporting documentation. Undocumented claims may not be processed. The Plan Administrator may request that you provide additional documentation before any claim is paid.

I certify that the information provided above is true and complete and that the expenses: (i) were incurred while I was a participant in the Plan and (ii) are not covered, paid, or reimbursed from any other source.

Employee Signature

Date

Note: Form must be signed in order to process the claim.

Instructions for Filing a Claim

Complete all information on the claim form for each amount claimed for reimbursement.

Make sure the claim does not include items for more than one plan year. Use different claim forms for different years.

Attach copy of an Explanation of Benefits (EOB) that supports each reimbursement request and shows the date the service was incurred.

Claim Form

If you mail your claim with EOB's, remember to keep a copy of the claim form and supporting documents for your records.

If you FAX your claim with EOB's, please remember to keep the original claim form and supporting documents for your records.

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
317-845-3539