



# DEBIT CARD SUBSTANTIATION

Use this form to verify a claim that has already been reimbursed by the use of your debit card.

Participant Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Medical	Date Incurred	Amount
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Total \$ \_\_\_\_\_

Dental	Date Incurred	Amount
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Total \$ \_\_\_\_\_

Vision	Date Incurred	Amount
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Total \$ \_\_\_\_\_

Dependent Care	Date Incurred	Amount
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Total \$ \_\_\_\_\_

### Dependent Care Provider Information (must be completed with dependent care claims)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Tax ID #: \_\_\_\_\_ (We cannot process dependent care claims without this information)

I hereby certify that the information on this form is true and accurate and that I believe these expenses are eligible under my flexible spending account program. I have not and will not receive reimbursement from any other plan for these expenses. I understand that reimbursement of an expense is not a guarantee by either Nyhart or my employer that if audited, the IRS will allow this expense. If my claim is disallowed, I alone am responsible for interest, penalties, and taxes due as a result.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Names of Dependents (for whom expenses are currently being submitted)

Dependent Name	Date of Birth	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____