nyhart

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	$ 0
Dental		
		$
		$
		$
		$
	Total	$ 0
Vision		
		$
		$
		$
		$
	Total	$ 0
Dependent Care		
		$
		$
		$
		$
	Total	$ 0

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**