nyhart

MILEAGE REIMBURSEMENT REQUEST

To receive reimbursement for mileage, you must complete this form and attach a copy of the bill from the medical provider who treated you.

Employee Name: SSN:

Name and Address of Medical Provider	Date(s) Incurred	Miles (Total)

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.

I authorize release of payment through my reimbursement account.

Employee Signature: Date:

Employer:

Where To Send a Claim:

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