



Reimbursement Claim Form

Please complete this form to request reimbursement of expenses incurred by you and/or eligible dependents. Itemized documentation of each expense must be provided. For questions, contact Customer Care at 877-466-1999

Participant Information

Participant Name:

Employer Name:

Email address & Home Address:

Please list each eligible expense below

Under the **Benefit Type** column, select one of the following benefit codes for each expense.

FSA – Health FSA **DCA – Dependent Care Account** **HRA-Health Reimbursement Arrangement** **DVFS – Dental/Vision Health FSA**
LPFSA - Limited Purpose Health FSA **QSEHRA – Small Employer HRA** **ICHRA - Individual Coverage HRA** **COMM - Commuter Benefits**

Under the **Service Code** column, select one of the following service codes.

MD – Medical **RX – Prescription Drugs** **OT – Over-the-Counter** **VS – Vision** **DN – Dental** **PM - Premium**

RedQuote Card Used	Benefit Type	Date of service	Service Code	Service Provider	Dollar Amount
TOTAL					

For quick reimbursement, file online via your employee portal or Mobile App!

Submit your claim form with documents via email to Admin@redquote.com.

Submit your claim form with supporting documentation via FAX to 253-858-5770.

To the best of my knowledge and belief, my statements on this Request for Reimbursement are complete and true. I am requesting reimbursement only for eligible expenses incurred during the applicable Plan Year and for eligible Plan Participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I further understand that it is my responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible requests, as doing so may delay payment. I authorize my Flexible Spending Account balance to be reduced by the amount requested.

Signature	Date
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