Medical Expenses
Request for Reimbursement through HSA Today
CLAIM FORM

NAME:		**SSN**	
Email:			
Address:			
Phone:			

Date of Service MM/DD/YY	Patient Name	Relationship	Name of Provider	Description of Service	Claim Amount
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
				Total:	$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Employee Signature:_____ **Date:** _____ /_____ /_____

SEND CLAIMS TO:

AWM

SUPPORT@AWM.CC

 Please do NOT include Cover Sheet with Faxed Claims*