

# Sec. 125 HCR & DCR Reimbursement Request



IRS Section 125

Health Care Reimbursement (HCR) Account & Dependent Care Reimbursement (DCR) Account

## I. Employee Information

Your Employer ( )	Your Name
Day time telephone number	Social Security Number

## II. Certification

**I certify that the following reimbursement submissions are for expenses incurred for my spouse, eligible dependent or myself. I will not receive payment from any other source for any of these expenses.**

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

Documentation must be attached to verify all submissions and must include the name and address of service provider, the dates of service, a detailed description of the service rendered, and the charge for the service. Cancelled checks and credit card receipts are not sufficient forms of receipt. Acceptable forms of documentation are:

- Co-payments receipts for office visits and receipts from dependent care providers
- Pharmacy prescription receipt
- Copy of Explanation-of-Benefits from your insurance company showing that the charges were not covered

## III. Health Care Reimbursement Submissions

Dates of Service	Type (Rx, co-pay, contact solution, etc)	Cost
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
	TOTAL:	\$

## IV. Dependent Care Reimbursement Submissions

Dates of Service	Dependent(s) Name	Age	Name & Address of Provider	Cost
				\$
				\$
				\$
				\$
				\$
			TOTAL:	\$

Fax claims to: 860-673-2207  
 Mail claims to: Advanced Benefit Strategies  
 30 Mill Street  
 Unionville CT 06085

Questions?  
 Call 860-675-2261  
 Toll Free 877-732-8125  
 Or, visit our web site @ [www.abs125.com](http://www.abs125.com)