COMBINED CLAIM FORM
HEALTHCARE OR DEPENDENT CARE SPENDING ACCOUNTS

Employee Name ________________________________

Address ________________________________ **Mark if NEW address** ☐

____

Employer Name ________________________________

Date Expense Incurred	Name of Service Provider	Expense Description *	Account H=Health FSA D=Dependent FSA	Net Amount
	Total Expense Claim			**$**

* Please attach statements, bills or receipts for each claim

** OTC medications and supplies may require a Certificate of Medical Necessity

Email Address: ________________________________ **Please confirm receipt of claim:** ☐

Employee Signature: ______________________________ **Date:** ________________________

My signature certifies that the above medical or dependent care expense has not been reimbursed by, or is not reimbursable under, any other coverage.

Mail or fax claims to:
BMC Benefit Services
790 Penllyn Pike, Suite 217
Blue Bell, PA 19422
Tel: 215-628-2500
Fax: 215-628-2591