COLUMBIA UNIVERSITY HUMAN RESOURCES

University Spending Account (USA) Reimbursement Request Form

Instructions

For reimbursement from your USA account for eligible ***medical***, ***dental***, and/or ***dependent day care*** expenses, fill out this form and sign it. The minimum reimbursement from your account is $25 per month. Reimbursement checks will only be made payable to you. ***Please submit the form to:*** *EBPA, P.O. Box 1140, Exeter, NH 03833-1140.* ***Deadline:*** *Expenses incurred during the current calendar year must be submitted by March 31 of the following year.* ***For questions, please call EBPA:*** *1-800-258-7298.*

Employee Information

Social Security Number: ___ – ___ – ____ Last Name: _____ First Name: _____

Address: _____ Apt. #: _____ City, State, ZIP: _____

Group Number: **586** Date *(mm/dd/yyyy)*: ___/___/____

Medical/Dental Account ***Attach another form if you need additional space.***

Identify each expense as "Medical," "Dental," "Vision," "Hearing," or "Other." List reimbursable expense(s) and attach explanation of benefits or itemized bill. Enter the amount you have received from all health plans to cover the expense. If you don't have a health plan or did not receive payment, write "0.00."

Patient Name	Expense Type	Dates of Care (mm/dd/yyyy)	Total Bill	Health Plan Payment	Reimbursement Amount
	☐ Medical ☐ Dental ☐ Vision ☐ Hearing ☐ Other: _____	/ / to / /	$	$	$
	☐ Medical ☐ Dental ☐ Vision ☐ Hearing ☐ Other: _____	/ / to / /	$	$	$
	☐ Medical ☐ Dental ☐ Vision ☐ Hearing ☐ Other: _____	/ / to / /	$	$	$
	☐ Medical ☐ Dental ☐ Vision ☐ Hearing ☐ Other: _____	/ / to / /	$	$	$
	☐ Medical ☐ Dental ☐ Vision ☐ Hearing ☐ Other: _____	/ / to / /	$	$	$
		Totals:	$	$	$

Dependent Day Care ***Attach another form if you need additional space.***

List each dependent and the dependent's care provider. Attach an itemized bill for each amount listed. In lieu of an itemized bill, have the care provider sign this form.

Dependent Name	Relationship	Age	Dates of Care (mm/dd/yyyy)	Provider	Taxpayer ID or Soc. Sec. #	Provider Signature*	Bill**
			/ / to / /				$
			/ / to / /				$
			/ / to / /				$
			/ / to / /				$
			/ / to / /				$
						Total:	$

* Provider signature required if you have no copy of bill. ** Attach copy of bill if you have it.

Your Signature

By signing this form, you certify that: (1) You or your eligible dependents have incurred the listed expenses. (2) All applicable insurance and/or other health plan benefits have been exhausted. (3) You will not deduct or take as a tax credit on your Federal Income Tax Return the listed expenses. (4) You assume all responsibility for taxes or penalties arising out of disallowed deductions.

Signature: _____ Date *(mm/dd/yyyy):* _____