VANTAGEPOINT
BENEFIT ADMINISTRATORS
20 Blake Avenue • Lynbrook, NY • 11563-2506
Tel: 516 599-2120 • Fax: 516 599-8310

**MEDICAL REIMBURSEMENT CLAIM FORM – HRA and FSA**

Fastest method: Sign into your Employee Portal from vantagepointbenefit.com, Account Login. Submit a claim via the *Online Claim Entry* on the main page and upload the appropriate backup (.pdf, .jpeg). If you cannot upload your backup, print the form and fax to 516-599-8310. You will receive an automated email when the claim is received.

Your Employee Portal also has valuable account information, balances, reimbursement tracking and eligible FSA expense lists, including FSA OTC doctor's note requirements.

If you do not have internet access, complete and sign this form and fax with your backup to: 516-599-8310, email to: claims@vantagepointbenefit.com or mail to: VantagePoint Benefit Administrators, Attn: Claims Department, 20 Blake Avenue, Lynbrook, NY 11563. No notification of receipt will be sent.

| | |
|---|---|
| **Company** | |
| **Employee** | |
| **Employee SSN** | |
| **Email** | |

| **Date of Service** From | To | **Provider Name** (Physician, Hospital, Pharmacy, etc) | **Service Type** (Office Visit, Rx, Lab etc.) | **Person for Whom the Expense was Incurred** | **VantagePoint Debit Card used for this expense?** | | **Amount Requested** |
|---|---|---|---|---|---|---|---|
| | | | | | **YES** □ | **NO** □ | |
| | | | | | **YES** □ | **NO** □ | |
| | | | | | **YES** □ | **NO** □ | |
| | | | | | **YES** □ | **NO** □ | |
| | | | | | **YES** □ | **NO** □ | |
| | | | | | **YES** □ | **NO** □ | |
| | | | | | **YES** □ | **NO** □ | |
| | | | | | **YES** □ | **NO** □ | |
| | | | | | **YES** □ | **NO** □ | |
| | | | | | **YES** □ | **NO** □ | |
| | | | | | **YES** □ | **NO** □ | |
| | | | | **Total Amount Requested** | | | |

**To avoid delays in processing your claim please sign and date this form and provide notice of any name or address change to VantagePoint immediately.**

I authorize my account(s) to be reduced by the amount requested. To the best of my knowledge and belief, the statements on this form are complete and true. I am claiming reimbursement for eligible expenses incurred by myself or a tax qualified dependent during the applicable plan year. I certify that these expenses have not been previously reimbursed by this or any other benefit plan will not be reimbursed from any other source and will not be claimed as an income tax deduction.

Employee Signature:_____ Date:_____