Blue Cross Blue Shield of Rhode Island

***Please Send Completed Form With Receipts To:***
*CDH Administration*
*40 Commercial Way, E. Providence, RI 02914*
*Email: BCBSRIclaims@londonhealthusa.com*
*Fax: 401-435-3937*

# Spending Account Reimbursement Claim Form

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|---|
| Employer Name: |
| Employee Name: |
| If Dependent, Name: |
| Phone: |
| Employee ID #: |

**Health Care Expense Claims: (HRA and/or FSA)**

| Account Type HRA | Account Type FSA | Date of Service | Provider Name | Provider Phone # | Service Provided | Amount Requested |
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| | | | | Total Amount Requested: | | |

**Dependent Day Care Claims: (FSA Only)**

| Dependent Name | Date of Service From | Date of Service To | Day Care Center | Day Care Center Phone # | Type of Service (Day Care, Pre-K, Day Camp, Etc.) | Amount Requested |
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| | | | | Total Amount Requested: | | |

**Transportation Expense Claims: (FSA Only)**

| Expense Type Parking | Expense Type Transit | Date of Service From | Date of Service To | Location | Mode of Transportation | Description of Expense (Mass Transit, Bus, Commuter, Etc) | Amount Requested |
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| | | | | | Total Amount Requested: | | |

I certify that the above information given by me in support of this claim is true and correct.

Member's Signature: Date:

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**For Questions please call:**
Local: 401-459-5000
Out of State: 1-800-639-2227

**Plan Administrator**: London Health Administrators

**Timely filing:** All reimbursement requests must be sent within 90 days of the service date unless London Health determines that unusual circumstances warrant a delay.