Health Care Expense Reimbursement Claim Form

Phone: (509) 534-0600
Toll Free: (800) 872-8979
Submit Claims via: **Email:** incent@rehnonline.com
Fax: (509) 535-7883

PARTICIPANT INFORMATION *(Claim may be denied if information is incomplete or not legible)*

Employer Name _____ **Last 4 Digits of Participant SSN** _____

First Name _____ **Last Name** _____ **Date of Birth** *(mm/dd/yyyy)* _____

Mailing Address ☐Check here if new _____ **City** _____ **State** _____ **Zip** _____

Email Address *(home or personal recommended)* ☐Check here if new _____ **Phone Number** ( ) -

HEALTH CARE REIMBURSEMENT INFORMATION *(Electronic submission of your claim can be done securely at INCENT.rehnonline.com)*

Date of Service	Name of Service Provider	Expense Description	Person Incurring Expense	Amount
Please attach an itemized statement from your provider or an Explanation of Benefits (EOB) from the Insurance Carrier		**Total Health Care Expense Reimbursement Request**		**$**

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed, by submission of this form, were provided during a period while the undersigned was covered under the Company's Flexible Benefit Plan or Health Reimbursement Arrangement with respect to such expenses and that the medical expenses have not been reimbursed prior and that the undersigned will not seek reimbursement under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned. Unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including Federal, State, or City income tax on amounts paid from the Plan which relate to such expense.

Participant Signature _____ Date _____

Health Care Expense Reimbursement Claim Filing Instructions

Please keep all original documents for your records!!

When submitting a claim, you must attach supporting documentation showing the following information:

1. Date of Service (not the date paid)
2. Services Rendered
3. Provider Name
4. Dollar Amount (finance charges are not eligible)

Cancelled checks, credit card slips, balance forward statements or bank statements are **NOT ACCEPTED.**

Submit your claim(s) to Rehn & Associates via:

- **Email:** INCENT@rehnonline.com
- **Fax:** (509) 535-7883. Please number each page (i.e. page 2 of 3, page 3 of 3, etc.)
- **Mail:** Incent Plan, PO Box 5433, Spokane, WA 99205

Please visit www.INCENT.rehnonline.com to:

- View your account balance
- Complete and submit a claim electronically
- Review claims history
- View Eligible Expenses
- Update your personal account information
- And much more!