REQUEST FOR REIMBURSEMENT
CONTINUATION FORM

COMPANY NAME: _____

Employee Name:_____

Social Security Number:_____

☐ **HEALTH CARE EXPENSE – FSA or HRA** **PROVIDE THE FOLLOWING INFORMATION**
Statement from the Healthcare Provider listing: √ Date(s) of Service √ Description/Type of Service √ Charges

☐ **CHILD CARE – DAY CARE EXPENSE** **PROVIDE THE FOLLOWING INFORMATION**
Statement from the Daycare Provider listing: √ Date(s) of Service √ Provider's signature √ Charges

☐ **PRIVATE MEDICAL INSURANCE PREMIUM** **PROVIDE THE FOLLOWING INFORMATION**
Statement from the Insurance Provider listing: √ Date(s) of Coverage √ Provider's name √ Charges

DATE(S) OF SERVICE	DESCRIPTION/TYPE OF SERVICE/PROVIDER	REQUESTED AMOUNT
	Claim Total	**$**

• P.O. Box 2260 • Coeur d'Alene, ID 83816-2260 • (208) 765-9500 • (800) 735-1115 • FAX (208) 667-6570
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