Nyhart.com

Debit Card Substantiation

Use this form to verify a claim that has already been reimbursed by the use of your debit card.

Employee Name: ______________________ **SSN:** ______________

Medical	**Date Incurred**	**Amount**
		$
		$
		$
	Total	$

Dental	**Date Incurred**	**Amount**
		$
		$
		$
	Total	$

Vision	**Date Incurred**	**Amount**
		$
		$
		$
	Total	$

Dependent Care	**Date Incurred**	**Amount**
		$
		$
		$
	Total	$

Dependent Care Provider Information (must be completed for dependent care claims)

Name ______________________

Address ______________________

City ______________________ **Zip** __________

Tax ID # ______________ (We cannot process dependent care claims without this information.)

I hereby certify that the information on this form is true and accurate and that I believe these expenses are eligible under my flexible spending account program. I have not and will not receive reimbursement from any other plan for these expenses. I understand that reimbursement of an expense is not a guarantee by either Nyhart or my employer that if audited, the IRS will allow this expense. If my claim is disallowed, I alone am responsible for interest, penalties, and taxes due as a result.

Employee Signature______________________ Date______________

Names of Dependents: (for whom expenses are currently being submitted)

Dependent Name	**Date of Birth**	**Relationship**