*my*SourceCard® Debit Card Substantiation Request Form

Employer Name:	**HENDRIX COLLEGE**		
Employee Name:	Last First Mi	**SS#:**	
Employee Address:	Street City State ZIP	**PHONE:**	( )
Email Address:			

☐ **Please check if this is a new address**

Please read the Reimbursement Account Rules and Claim Filing Instructions provided online before completing this claim.

* Information below must be completed

MEDICAL EXPENSE CLAIMS

*my*SourceCard® Transaction	Dates of Service	Patient Name	Relationship	Name of Provider	Description of Service	Claim Amount
☐ Yes ☐ No						$
☐ Yes ☐ No						$
☐ Yes ☐ No						$
☐ Yes ☐ No						$
☐ Yes ☐ No						$
☐ Yes ☐ No						$
☐ Yes ☐ No						$
☐ Yes ☐ No						$
☐ Yes ☐ No						$
☐ Yes ☐ No						$
☐ Yes ☐ No						$
☐ Yes ☐ No						$
☐ Yes ☐ No						$
☐ Yes ☐ No						$
☐ Yes ☐ No						$
					Total:	$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement indicated on this substantiation form were incurred by me (and/or my spouse and/or eligible dependents), and were not reimbursed by any other plan nor will I seek reimbursement from any other source. To the best of my knowledge and belief, the expenses are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ Date: _____ /_____ /_____

FOR FASTEST PROCESSING, FAX TO: (501) 687-3282, TOLL FREE 1-888-472-6777

Email to info@idpas.com , Or mail to:

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