

Debit Card Substantiation Form

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



Name: _____

SS#: _____

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 will not 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 plan. 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 ASAP Flex Plans, Inc. 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 being submitted)

Dependent Name	Date of Birth	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____