BASIC

Please type or print all information.

THIS FORM CAN BE USED FOR EITHER YOUR FSA OR HRA ACCOUNT WITH BASIC

COMPANY NAME: (required for processing)

Social Security Number: (for security purposes please provide at least the last 4 digits of your ss#)

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Employee Last Name:

Employee First Name:

MEDICAL EXPENSES

- Documentation for each request will need to show date of service, description of service provided and charge for service as well as the providers name and address.
- For expenses that apply to your deductible or co insurance please submit a copy of the Explanation of Benefits (EOB) from your insurance carrier
- Please itemize your expenses to help assure proper processing. If you have more expenses than this form allows please attach a separate form. If you do not itemize your expenses we will process your claim based on the documentation received
- Mail claims to: 9246 Portage Industrial Dr, Portage MI 49024; Fax: 800-731-1922 or 269-488-6255 or Email to hra@basiconline.com
- For questions please call 888-472-0777 or 269-488-6785

Date of service	Provider name or name of store	Amount

DAY CARE EXPENSES (dependent care account)

- Please have your day care provider sign this form on the line below or provide a receipt for the services

Dates of service	Day care provider name	Amount

SIGNATURE OF DAY CARE PROVIDER: