Claim Form

Mailing Address:
Consumer Health Solutions
PO Box 218
North Reading, MA 01864

Contact Us:
HealthAccounts@ConsumerHealthSolutions.com
Leave a Voicemail: 877-230-8650 x101
Fax: 978-451-0981

This form can be used to submit for reimbursement through your CHS account (except dependent care). You are required to attach a copy of the appropriate documentation based on your plan.

- **HRA:** Explanation of Benefits (EOB) from your medical carrier showing the expense is required.
- **FSA/Limited Purpose FSA or Adoption**:
  - If services were provided: Provider name, patient name, date of service, services provided, amount.
  - If items were purchased: Store name, date of purchase, items purchased, amount.
- **Tuition**: Invoice for expenses and grades/certification of completion.

Please complete the form in its entirety. Failure to complete the form in entirety, or failure to provide an itemized receipt or invoice will result in a request for more information or claim denial.
Claims can also be submitted through the Consumer Health Solutions Portal (https://CrossAgency.lh1ondemand.com) or on the Mobile App "Consumer Health Mobile."

Account Holder Information:		
First Name:	Last Name:	Employer:
Email Address:	Phone:	
Mailing Address Line 1:	Mailing Address Line 2:	
City:	State:	Zip:

Reimbursement Description:
Please write a brief description of the reimbursement you are seeking including the account/plan you are seeking reimbursement from (HRA / FSA / Other).

Expenses Incurred:				
Patient Name	Provider Name	Type of Expense	Date of Service (From-To)	Expense amount

Required Documentation:

☐ I have provided the required documentation to support this reimbursement request.

Authorization:

I certify that the incurred expenses for which reimbursement is sought were incurred by myself or my eligible dependents and that these expenses have been incurred during the Plan Year. I further declare that I am requesting payment only for expenses that have not and will not be paid under any other benefit plan or program; Reimbursement cannot be requested until after the last day of the service period. I am solely responsible for the accuracy and veracity of all information relating to this claim. I authorize that I am requesting reimbursement in the amount requested from my applicable account.

Signature	Name (Print)	Date

Retain any original receipts or a copy of the claim and receipts for your personal records.