CDCS HEALTH CLAIMS INC. Health Care Spending Account (HCSA) Claim Form

You may pay less if you submit your health and dental expenses to all other insurance and benefit plans first, and then pay any unpaid portions of these expenses from your health care spending account (HCSA)
Please check the appropriate box below to choose how you want your expenses paid. We will process your claim based on your instructions on this claim form

☐ **I want to submit my expenses to CDCS' health plan or dental plan first. I would like any unpaid portions of my expenses paid from my health care spending account.**

- Complete a standard CDCS health claim or dental claim form.
- Complete all parts of this form.
- Staple together all itemized original receipts, original statements, and claim forms.
- Mail to the applicable address on the standard CDCS health claim or dental claim form.

☐ **I do not want to submit my expenses to CDCS' health plan or dental plan. I would like the entire expense amount paid from my health care spending account.**

- Complete all parts of this form.
- Circle or highlight the expense and the amount to be paid on each original receipt or original statement.
- Staple all receipts and statements to this form.

Patient's name (first and last)	Relationship to Employee	Description Of expense	Practitioner, dentist or Supplier name	Date of visits Of purchase DD	MM	YYYY	Amount to be reimbursed for each expense
	☐ self ☐ spouse ☐ child ☐ other						$
	☐ self ☐ spouse ☐ child ☐ other						$
	☐ self ☐ spouse ☐ child ☐ other						$
	☐ self ☐ spouse ☐ child ☐ other						$
	☐ self ☐ spouse ☐ child ☐ other						$
	☐ self ☐ spouse ☐ child ☐ other						$
Total of all health and dental expenses							$

Employee's name _____ Address _____
Last First (in full) Street/Apt.#RR#

_____
City Province

Date of birth ____ ____ ____ Sex ☐ Female ☐ Male
Day Month Year

Policy/plan no. _____ Member ID _____ Postal code _____ Phone no. _____

I certify that the information given on this form is true, correct and complete to the best of my knowledge. I declare that the dependants for whom expenses are being submitted are dependent on me for maintenance or support as required by the Canada Customs and revenue Agency or the Quebec Taxation Act. I authorize the release, by any health care provider, CDCS or any of its agents, of any information necessary for the administration of this claim or my group plan. A photocopy of this authorization is as valid as the original.

Employee's signature _____ Date ____ ____ ____
Day Month Year

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