CATAPULT

HEALTHCARE REIMBURSEMENT ARRANGEMENT CLAIM

PERSONAL INFORMATION (Please Print Clearly)

Company Name_____ Social Security #_____

Employee Name _____ Telephone #_____

Street Address_____ City/State/Zip:_____

Email _____

CLAIM / REIMBURSEMENT INFORMATION

Date of Service	Provider	Claim Amount	Amount to be Reimbursed

EMPLOYEE AUTHORIZATION

I certify that the expenses for which I am requesting reimbursement meet all of the following conditions listed below:

- They were incurred by me for services or supplies under the Plan; o They were for services or supplies furnished on or after the effective date of this Plan Year; and o I have not, nor will I be, reimbursed for these expenses in any other way.

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which I am covered. I understand that reimbursement will be made in accordance with the provisions of the Plan. I accept responsibility for the proper treatment of benefits paid under this plan.

Employee Signature: _____ Date of Request: _____

You must attach your most recent explanation of benefits (EOB).

Send your completed request form, with the required documentation attached, to:
(Live checks are cut and mailed every Friday; claim submission deadline for checks is Wednesdays at 4:00 pm)

CATAPULT
Attn: FSA Services
9140 Arrowpoint Blvd, Suite 140, Charlotte, NC 28273
Fax to: 704.944.6076
Email to: claims@letscatapult.org
Questions: Call (800)528-2398