Blue Cross Blue Shield of Rhode Island

Please Send Completed Form With Receipts To:
CDH Administration
40 Commercial Way, E. Providence, RI 02914
Email: BCBSRIclaims@londonhealthusa.com
Fax: 401-435-3937

Spending Account Reimbursement Claim Form

Employer Name:
Employee Name:
If Dependent, Name:
Phone:
Employee ID #:

Health Care Expense Claims: (HRA and/or FSA)

Account Type HRA - FSA		Date of Service	Provider Name	Provider Phone #	Service Provided	Amount Requested
				Total Amount Requested:		

Dependent Day Care Claims: (FSA Only)

Dependent Name	Date of Service From----To	Day Care Center	Day Care Center Phone #	Type of Service (Day Care, Pre-K, Day Camp, Etc.)	Amount Requested
	I				
	I				
	I				
	I				
	I				
			Total Amount Requested:		

Transportation Expense Claims: (FSA Only)

Expense Type Parking---Transit	Date of Service From----To	Location	Mode of Transportation	Description of Expense (Mass Transit, Bus, Commuter, Etc)	Amount Requested
I	I				
I	I				
I	I				
I	I				
I	I				
			Total Amount Requested:		

I certify that the above information given by me in support of this claim is true and correct.

Member's Signature: Date:

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For Questions please call:
Local: 401-459-5000
Out of State: 1-800-639-2227

Plan Administrator: London Health Administrators

Timely filing: All reimbursement requests must be sent within 90 days of the service date unless London Health determines that unusual circumstances warrant a delay.