

Commuter Benefits

Pay Me Back Claim Form



TOLL-FREE FAX: (877) 353 - 9236

Or, mail to: Claims Administrator, PO Box 14053, Lexington, KY 40512

Pay Me Back Claim Form Instructions

PLEASE READ THIS BEFORE SUBMITTING YOUR CLAIM FORM

Your claim is important, but in order for us to process it and your reimbursement quickly and fully, we need you to completely and accurately fill out and submit the Pay Me Back (PMB) claim form. To help you, we've provided the below guidelines. Please follow them when completing and submitting your claim.

Tips for Filling out the Pay Me Back Claim Form

- Do not file a claim for any pass purchased or for parking paid using the Pay MyParking service
- Read every box and provide all requested information pertaining to you and your claim
- Provide the legal name your employer has for you in your official records, not your nickname
- Be sure to complete a separate line for each month when filling in your claim forms (e.g. \$120 for January, \$150 for February). Do not submit an annual amount or date range
- Make sure to total the reimbursement amount and enter it at the box at the bottom of the form
- Make sure you sign the form

Things to Remember When Including Receipts

- Include a receipt for every expense
- A canceled check is not an acceptable form of receipt
- Each receipt must include the date(s) of service
- Do not send original receipts; keep them for your own records
- If you attach multiple receipt pages, circle or check the dollar amount that is being claimed for each receipt
- Do not use a highlighter to highlight the dollar amount on the receipt

Tips for Submitting the Pay Me Back Claim Form by Fax

- Do not use a cover page
- Use a high-speed fax machine with a transmission speed of at least 9.6 kbps or 15 sec. per page
- Do not combine and submit a co-worker's claims with yours

- Sign the form.
- Send a photocopy of your receipt.
- Keep original receipt with a copy of this completed form.
- Do not file a claim for any pass purchased or for parking paid using Pay My Parking.



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ACCOUNT HOLDER INFORMATION

Last Name											First Name										
ID Code (last 4 digits)*				Employer / Program Sponsor's Name																	
Zip Code				Birth Month/Day (MM/DD)			Email Address (complete only if new)														

CERTIFICATION AND AUTHORIZATION

- My signature certifies that
- The information on this page is accurate and complete.
 - I am requesting reimbursement for my own personal expenses.
 - These services have already been provided.
 - I have not and will not seek reimbursement of this expense from any other plan or party.
 - If No Receipt Provided is checked, this service provider does not provide receipts (such as payments made by token/ticket machine, meter or cash box).
 - If Use Balance to Pay for Next Commuter Order is checked, I request that any remaining balance for the benefit month indicated be turned into a credit that will reduce my next pre-tax payroll deduction.
 - If this is a Public Transportation expense, then the pass for this service in this amount is not available for purchase.
 - Use of this service indicates my acceptance of the User Agreement at www.HealthEquity.com/WageWorks (available upon registration; enter user name and password or click on First Time User? link).

Signature of Account Holder **X** _____ Date _____

CLAIMS FOR OUT-OF-POCKET EXPENSES

1	<input type="radio"/> Parking <input type="radio"/> Vanpool <input type="radio"/> Pub Trans	Benefit Month (MM/YY) [][] / [][]	Out-of-Pocket Cost \$ [][] [][] [][] [][]
	Name of Parking Facility or Service Provider _____		<input type="checkbox"/> No Receipt Provided <i>If so, you can file online claim instead.</i>
		<input type="checkbox"/> Use Balance to Pay for Next Commuter Order <i>If not, you can still file claims for this Benefit Month (up to available balance).</i>	

2	<input type="radio"/> Parking <input type="radio"/> Vanpool <input type="radio"/> Pub Trans	Benefit Month (MM/YY) [][] / [][]	Out-of-Pocket Cost \$ [][] [][] [][] [][]
	Name of Parking Facility or Service Provider _____		<input type="checkbox"/> No Receipt Provided <i>If so, you can file online claim instead.</i>
		<input type="checkbox"/> Use Balance to Pay for Next Commuter Order <i>If not, you can still file claims for this Benefit Month (up to available balance).</i>	

3	<input type="radio"/> Parking <input type="radio"/> Vanpool <input type="radio"/> Pub Trans	Benefit Month (MM/YY) [][] / [][]	Out-of-Pocket Cost \$ [][] [][] [][] [][]
	Name of Parking Facility or Service Provider _____		<input type="checkbox"/> No Receipt Provided <i>If so, you can file online claim instead.</i>
		<input type="checkbox"/> Use Balance to Pay for Next Commuter Order <i>If not, you can still file claims for this Benefit Month (up to available balance).</i>	

* Your ID Code is the last 4 digits of your Social Security Number, your Employee Number or other reference number assigned by your program sponsor. Please check the enrollment instructions provided by your program sponsor for more information about your ID Code.

\$ [][] [][] [][] [][]
TOTAL THIS FORM

YOU MUST ATTACH APPROPRIATE PROOF OF SERVICE FOR EACH AMOUNT ABOVE OR CHECK "NO RECEIPT PROVIDED."

- Sign this form. • Send a photocopy of your receipt. • Keep original receipt with a copy of this completed form.
- Do not file a claim for any pass purchased or for parking paid using Pay My Parking.