

**HARDING UNIVERSITY**  
Medical Spending Account  
Reimbursement Claim Form

Employee Name: \_\_\_\_\_ Banner ID#: \_\_\_\_\_

Campus Box #: \_\_\_\_\_

**Instructions**

1. For medical/dental expense claims that were submitted to a medical plan or an insurance company but not paid by that carrier, attach copies of other insurance carrier claim and/or payment forms (explanation of benefit (EOB) forms) to establish amounts not covered under the medical/dental plan.
2. For all other reimbursable expenses, copies of all bills must be attached which show who (name and address) rendered the service, reason for charge and date and amount of charge. Cancelled checks are not acceptable receipts.
3. Submit this form to Office of Human Resources. Retain a copy for your records.

**Employee Certification**

I hereby certify that all items requested to be reimbursed comply with the Harding University Medical Spending Account and such items have not and will not be covered by any other plan or program of any employer or other person. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns for any year. Harding University does not accept responsibility for direct payment to any individuals other than the employee.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date