

**FOR FASTER PROCESSING, FAX this Form and Receipts to:
866-266-4853**

or Mail Form and Receipts to:
Chappelle Benefits
P.O. Box 59548 Birmingham, AL 35259
(PLEASE KEEP YOUR ORIGINALS)



Questions?
Email us at: acclaris.support@chappellebenefits.com
or call us at 800-257-0986

mbi MasterCard DEBIT CARD RECEIPT TRANSMITTAL COVER SHEET

Your compliance is required to meet IRS required FSA Debit Card receipt review



Use this cover sheet if you are faxing or mailing
mbi MasterCard Receipts. This is not a claim reimbursement form.
Reimbursements will not be processed if this form is used.

Employee Name _____ Employee ID / SSN _____ - _____ - _____
Daytime Phone Number _____ Email Address _____
Employer Name _____ MBI MasterCard Number _____

Attach copies of your receipts with this cover sheet. Acclaris will receive your FAX and secure the content according to HIPAA Privacy requirements. Be sure that you or others on your behalf secure your data at the point of origination. Original receipts will not be returned. Note: The customer is responsible for misrepresentation regarding requests for reimbursement. If you have any further questions please contact customer service.

Date and incurred costs

Transaction Date	Merchant Name	For Whom (name and relationship)	Amount
1. _____	_____	_____	\$ _____
2. _____	_____	_____	\$ _____
3. _____	_____	_____	\$ _____
4. _____	_____	_____	\$ _____
5. _____	_____	_____	\$ _____
6. _____	_____	_____	\$ _____
Use additional sheet(s) if necessary		TOTAL AMOUNT OF ATTACHED RECEIPTS	\$ _____

I certify that I am authorized to use the MasterCard issued and that by signing and using the debit card, I agree to all terms and conditions. I understand that any transactions initiated by my use of an authorized Card are subject to the terms and conditions of the Cardholder Agreement received with the Card. I certify that the qualified healthcare expenditures presented with this transmittal have been received by an eligible individual and are true and accurate. I further certify that these expenses have not, nor will be, reimbursed through insurance or any other arrangement.

Participant Signature X _____ Date _____