TRANSPORTATION REIMBURSEMENT CLAIM

COMPANY NAME		(PLEASE PRINT)

EMPLOYEE INFORMATION

MUST COMPLETE ALL SECTIONS

Last Name	First Name	MI	SSN
Address			
City	State	Zip Code	
Daytime Phone #			

REIMBURSEMENT REQUEST

Please indicate the total amount of qualifying expense for reimbursement below. Do not include amounts reimbursed by any other source. Attach any applicable bills, receipts, canceled checks, etc. to substantiate expenses. All substantiation must include dates service is scheduled or received, services provided, provider's name and amounts charged for reimbursement.

Qualified Parking Garage and Meter Expenses *(not to exceed $240 monthly reimbursement maximum)*

☐ Parking Facility Name: _____

Parking Facility Address:_____Phone: _____

☐ Metered Parking

Jobsite Address: _____

$_____ _____

Total Amount Requested — Month of Service

Qualified Mass Transit and Van Pooling Expenses *(not to exceed $125 monthly reimbursement maximum)*

☐ Mass Transit or Van Pool Provider:_____

Transit Station: _____

☐ Metered Parking

Jobsite Address: _____

$_____ _____

Total Amount Requested — Month of Service

CLAIM CERTIFICATION

- *I certify that these expenses for which reimbursement is claimed from Section 132 of the Qualified Transportation Reimbursement Plan have been incurred by me and are not payable by any other benefit plan or program.*
- *My qualified parking, mass transit and/or van pooling expenses have been incurred while I am an eligible participant of the plan.*
- *I have not and will not itemize and deduct, nor claim credit for these expenses on my individual income tax returns.*

_____ _____

Participant Signature — Date

GENERAL SUBMISSION TIPS

1. Complete all information in the **Participant Information** section.
2. Provide the following information in the **Reimbursement** section: Dates services received or scheduled (not the payment date); Service type (metered parking, parking garage fee, transit pass); Provider's complete name and address; Amount you wish to be reimbursed.
3. Sign and date the claim in the Claim Certification section.
4. Attach supporting documentation. Substantiation must accompany a completed copy of this form to consider claims for reimbursement.
5. Fax or mail this form and supporting documentation directly to:

AXIS Health Partners
12400 SE Freeman Way, Suite 102
Portland, OR 97222

Toll-Free Fax Number
800-476-8496

Important Reminders:

Payments are made to participants only. Alternate payees are not permitted. Keep copies of all receipts, checks and records. Originals cannot be returned. Items reimbursed cannot be claimed on your individual income tax return. Payments are issued after reciept and processing, subject ot adjudication. Transfers between reimbursement accounts are prohibited.