



### BlueFund MasterCard Validation Form

13511 Label Lane, Hagerstown, MD 21740  
Phone: (866) 208-8587 • Fax: (866) 556-5551

- DO NOT USE A FAX COVER PAGE -

DATE: \_\_\_\_\_

# OF PAGES: \_\_\_\_\_

**Important: Claims sent with this form will NOT be processed. This form is only for members with a BlueFund MasterCard and is used to validate purchases according to IRS regulations.**

#### Documentation Instructions

1. Please attach the receipt(s) from the provider(s) where you charged your HRA eligible expense(s) and fax it to BlueFund Administration at (866) 556-5551.
2. The receipt must detail the date of service, the name of your provider and the service(s) rendered.
3. Prescription claims must include the Rx number and a pharmacist receipt – please do not send the cash register receipt.
4. **Cash register receipts are only acceptable for over-the-counter items.**

Employer Name:	Employee Name:	Daytime Phone Number:	Social Security Number or ID:
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Amount	Date of Service	Provider Name	Comments
\$			
\$			
\$			
\$			

<b>Employee Certification</b>	I certify that these expenses for which I have received reimbursement is from the Health Reimbursement Account and have been incurred by me and/or my eligible dependents and are not, and will not, be payable by any other plan and will not be deducted on my federal, state or local income tax returns.	
	_____ Employee Signature	_____ E-mail address if we have a claim question
	_____ Date	

**Comments to the Claim Department:**

Note: If you submit a claim for the same type of service or item several times, you only need to submit documentation the first time. An example of this type of claim is a prescription drug from the same merchant for the same dollar amount. If you have any claims such as this, please complete the following:

Merchant Name: \_\_\_\_\_ Amount (\$): \_\_\_\_\_ Date of Last Charge: \_\_\_/\_\_\_/\_\_\_