Horizon Blue Cross Blue Shield of New Jersey

Horizon Blue Cross Blue Shield of New Jersey
Three Penn Plaza East PP-05S
Newark, NJ 07105-2200
Phone: (800) 224-4426
Fax: (973) 274-2215
www.HorizonBlue.com/fsa

Transportation Assistance Plan Reimbursement Request Form

EMPLOYEE NAME (PRINT) ______________________ ID # ______________________

HOME ADDRESS ______________________ HOME PHONE #: (______)______________

CITY STATE ZIP ______________________ WORK PHONE #: (______)______________

EMPLOYER NAME: ______________________

Instructions: *Complete the information for the Parking or Mass Transit expense(s) that you have incurred below. You must provide a copy of a receipt showing that you have incurred the expense(s). The receipt must include (1) Type of Expense, (2) Date Expense Incurred, (3) Name of Service Provider, and (4) Amount. Credit card receipts must contain items (1)-(4) to be acceptable. Be sure to provide all information requested on this form. Failure to provide this information will result in denial of the claim until such time as the information is provided. Print the information requested and fax the form and supporting documentation to (973) 274-2215 or mail the form to Horizon BCBSNJ, 3 Penn Plaza East, PP-05S, Newark, NJ 07105-2200 for processing.*

All Parking and Mass Transit claims for the plan year must be received by December 15th in order to be reimbursed.

	Expense (1)	Expense (2)	Expense (3)	Expense (4)
Date Expense Incurred				
Name of Service Provider				
Type of Service	☐ Parking ☐ Transit	☐ Parking ☐ Transit	☐ Parking ☐ Transit	☐ Parking ☐ Transit
Total				
Reimbursement Requested				

To the best of my knowledge and belief all statements made on this claim form are complete and true. I certify that I have received the services described on this claim form and have not received reimbursement from any other source.

Employee Signature: ______________________ *Date:* ______________

FOR EMPLOYER USE ONLY

BENEFITS ADMINISTRATOR: ______________________ DATE: ______________

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