

PARKING EXPENSE CLAIM FORM

Mail to:
UPMC Health Plan
PO Box 3169
Greenwood Village, CO 80155-3169

Phone: 1-888-876-2756
Fax: 1-866-229-3711

No. of pages _____

PLAN & EMPLOYEE INFORMATION

FIRST NAME: _____ LAST NAME: _____ MEMBER ID NUMBER: _____
 DAYTIME PHONE: () _____ EMAIL: _____ DATE OF BIRTH: ____/____/____
 EMPLOYER NAME: **UPMC** PLAN YEAR: _____

Note: Reimbursements will be sent to the address on file with UPMC. If an address change or update is needed, please contact your Human Resources office or update your information via My HUB.

EXPENSES

Please include receipts for all submitted expenses whenever possible. If a receipt was not available for your parking expense you can still be reimbursed by itemizing your parking expense(s) on this form and signing the authorization. Even without receipts, you should maintain records of your parking expenses in the event of an IRS audit. Please check the appropriate box indicating whether or not you are including a receipt for your claimed expense.

PARKING

SERVICE START DATE	SERVICE END DATE	SERVICE PROVIDER	\$ AMOUNT	RECEIPT ATTACHED
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
TOTAL PARKING EXPENSES			\$	

REIMBURSEMENT INFORMATION

- Pay this claim by direct deposit to my specified account on file.
- Pay this claim by direct deposit using the information provided below.
- Issue a check for this claim.

I hereby authorize UPMC Health Plan, Inc. and authorities on its behalf to initiate credit entries for my Commuter Parking reimbursements into my account designated below and, if necessary, make corrections for any entries made in error. This authority is to remain in full force and effect until UPMC Health Plan, Inc. has received written notification from me of its cancellation in such time and in such manner as to afford UPMC Health Plan, Inc. a reasonable opportunity to act.

ACCOUNT NUMBER: _____ ROUTING NUMBER: _____

BANK NAME: _____ CHECKING ACCOUNT SAVINGS ACCOUNT Must be 9 digits

EMPLOYEE AUTHORIZATION

To the best of my knowledge and belief, the expenses listed above are accurate, complete and are eligible for reimbursement under the plan. I certify that expenses will not be claimed again when filing IRS form 1040. I certify that these expenses were work related and incurred for myself. I certify that these parking expenses have not been reimbursed are not reimbursable under any other coverage or employer plans. I certify that I have acquired and retained a receipt where possible for the claims above. I certify that if my employer incurs a liability for failure to withhold Federal, State or local, or Social Security Taxes on one or more of my payments or reimbursements that are not Qualified Expenses, I will indemnify and reimburse the employer that liability.

Signature: _____ Date: _____