



-DO NOT USE A FAX COVER PAGE-

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### BlueFund MasterCard Validation Form

13511 Label Lane  
Hagerstown, MD 21740

Fax to 1-866-556-5551

Phone 866-208-8587

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

#### Documentation Instructions

1. Attach the receipt from the provider where you charged your HRA eligible expense & fax it to BlueFund Administration
2. The receipt must detail the date of service, provider and services. Please note credit card receipts are not acceptable.
3. Prescription claims must include pharmacist receipt with the Rx# and Name.
4. Please send only copies of receipts and keep the originals for your records.
5. **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/FSA Account 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.		
	_____ <b>Employee Signature</b>	_____ <b>Date</b>	_____ <b>E-mail address</b>

Comments to the Claim Department: