HealthPartners®

TRANSPORTATION AND PARKING EXPENSE REIMBURSEMENT CLAIM FORM

Employee Information (PLEASE PRINT)			**For Address changes please contact your HR Department**
Employee Last Name	First Name	Middle	Social Security Number
Employer's Name			Employee ID # (if applicable)
E-mail Address ☐ I would like an e-mail confirming this claim has been processed			Daytime Phone Number

☐ Some of these claims have been previously submitted

Transportation/Parking Expense Reimbursement

Month and Year of Expense	Name of Person Claiming Expense	Type of Expense	Amount Requested
		TOTAL	**$**

Parking Documentation

Attach receipts (if available) or note meter/parking expenses above. Vanpool - request the signature of your provider of transportation service(s) OR attach your transportation receipt to this form.

Provider Name	Provider Signature	Date

Employee Certification

I certify that the expense(s) listed above have been incurred by me and are for the purpose of commuting to and from my place of employment and qualify for reimbursement as defined by my company's transportation/parking program. These expenses have not been previously submitted for reimbursement, nor will I seek reimbursement from any other reimbursement program.

Employee Signature	Date

Return this form and supporting documentation by:	**Fax:** 952-883-5026	**Mail:** HealthPartners Service Center Membership Accounting, Mail Stop 21104A PO Box 1309 Minneapolis, MN 55440-1309	**Questions:** Metro Area: 952-883-7000 Outside Metro: 1-866-443-9352 TTY line: 952-883-5127 ***www.healthpartners.com***

Please retain a copy of this form and all attachments for your records.