



P. O. Box 4346, Missoula, MT 59806

# PARKING EXPENSE REIMBURSEMENT REQUEST

To send scanned claims, or for additional forms, go to:

[www.allegianceflexadvantage.com](http://www.allegianceflexadvantage.com)

FAX: 406-523-3149 or, toll-free 877-424-3539      PHONE: 406-721-2222 or, toll-free 877-424-3570

Please print legibly in black or blue ink.

Employee Name: _____	Employer Name: _____
Employee ID: _____ (Social Security Number or, if assigned, alternate ID)	# Pages Submitted: _____
Return Phone Number: _____ - _____ - _____	Please call to confirm receipt? Yes <input type="checkbox"/>
Attention: _____	Comments: _____

**Qualified Parking**

**For the Month of**

**Amount Paid**

_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

YOU MUST SUBMIT INDEPENDENT, 3RD-PARTY DOCUMENTATION OF YOUR EXPENSES WITH THIS CLAIM FORM (receipt showing service dates and fees paid).

I certify that the dates and services are true and that the claimed expenses have been incurred in connection with work-related parking.

Signature (required): \_\_\_\_\_ Date: \_\_\_\_\_

Check here if your address has changed. New address: \_\_\_\_\_  
\_\_\_\_\_