



REIMBURSEMENT CLAIM FORM

Fax Claims to:
(877) 775-1339 Attn: Lindsay

Total Pages _____

Name: _____ Soc Sec #: _____ Employer Name: _____
Please Print or Type

Address (only complete if new): _____ Daytime Phone: (____) _____

To receive reimbursement for eligible expenses incurred during the plan year, mail OR fax (not both) this completed and signed claim form along with IRS-required documentation of the expense from an independent third party (such as Insurance EOB, receipt or statement), which must include all of the following:

- Date of service / purchase
- Name of person receiving service
- Name of provider of service
- Type of service/supply provided (name of OTC item must be printed directly on the receipt by the register or else include a copy of the product packaging with price tag on it matching amount paid on receipt)
- Itemized Amount charged for each service/supply or the amount not reimbursed by insurance

- Orthodontia claims require an itemized statement on date of service and the orthodontist's contract or payment agreement showing monthly payment
- CREDIT CARD RECEIPTS, CANCELLED CHECKS, CHECK COPIES AND CASH REGISTER RECEIPTS ARE NOT ACCEPTABLE

HRA

Reimburse from Attached EOBs and / or Rx Receipts Reimburse ineligible from Flex

(See SPD For Eligible Expenses)

Coordination with another Insurance Carrier (Please submit EOB from other carrier i.e. Medicare, Priority, BCBS, Aetna)

Flex Health Care Expense Reimbursement

Date of Service	Physician or other Provider Of Service	Type of Service/Supply Purchased	Amount Paid	Amount to be Reimbursed
Total to be Reimbursed				\$

Flex Dependent/Child Care Expense Reimbursement

Dates of Service	Name of Person(s) Receiving Service	Relationship to Employee	Age(s)	Amount
Total to be Reimbursed				\$

Name of Provider: _____ Provider's Taxpayer ID# _____

Address of Provider: _____

Is Provider related to participant? Yes No If Yes, please describe: _____

*Signature of Care Provider _____ Date: _____

**If you DO NOT have a receipt with complete information your claim will not be reimbursed unless your daycare provider has signed this form.*

I hereby certify that all the medical expenses on this reimbursement form have been incurred by me, my spouse and/or my eligible dependents during the plan year and qualify for reimbursement. I understand that medical expenses are deemed to have been "incurred" when the services giving rise to the claim are rendered, regardless of when I am formally billed, charged or pay for the service. I certify the expenses are medical expenses as defined in Section 213(d) of the Internal Revenue Code of 1986, and are not for cosmetics, cosmetic surgery, premiums on accident or health insurance or coverage for long-term care services. I certify that these expenses have not been or will not be reimbursed under this or any other benefit plan. I also understand that any reimbursed expenses cannot be used to claim a deduction or credit on my personal income tax return. I agree to file IRS Form 2441 with my tax return and provide any required taxpayer identification numbers for reimbursements from my DCAP account. This is not a guarantee that the payment is tax-free if the requested items do not meet IRS rules.

Employee Signature X _____ Date: _____