PAYFLEX®

Reimbursement Account Claim Form

Fax or Email completed form and documentation to:
Fax: 1-844-306-8146
Email: PayFlex_Receipts@alegeus.com

To avoid claim processing delays, you must sign, date and complete this form.
You must also include supporting documentation.
WAIT! Did you know that you can file a claim online?
Log into www.payflexwallet.com.

Use dark pen and all UPPER CASE letters to complete the form.

Employee Information

Member ID (Employer assigned number or W ID)

Member Name

Last | First | MI

Member Address

Street

City | State | ZIP Code

Note: If you have an address change, please notify your employer. For security purposes, we can only accept an address change from your employer.

Employer Name

Health Care Expenses (For you, your spouse and your dependents)

Complete this section to request reimbursement. Information provided below must match your supporting documents.

CLAIM #1

Patient's Name

Patient type (check one): ☐ Myself ☐ My Spouse ☐ My Dependent

Start Date of Service (MM/DD/YYYY) **End Date of Service** (MM/DD/YYYY)

Expense type (check one): ☐ Deductible ☐ Medical ☐ Dental ☐ Vision ☐ Prescription (Rx) ☐ Over-the-Counter (OTC) ☐ Orthodontia

Amount

CLAIM #2

Patient's Name

Patient type (check one): ☐ Myself ☐ My Spouse ☐ My Dependent

Start Date of Service (MM/DD/YYYY) **End Date of Service** (MM/DD/YYYY)

Expense type (check one): ☐ Deductible ☐ Medical ☐ Dental ☐ Vision ☐ Prescription (Rx) ☐ Over-the-Counter (OTC) ☐ Orthodontia

Amount

CLAIM #3

Patient's Name

Patient type (check one): ☐ Myself ☐ My Spouse ☐ My Dependent

Start Date of Service (MM/DD/YYYY) **End Date of Service** (MM/DD/YYYY)

Expense type (check one): ☐ Deductible ☐ Medical ☐ Dental ☐ Vision ☐ Prescription (Rx) ☐ Over-the-Counter (OTC) ☐ Orthodontia

Amount

Employee Information

Member ID (Employer assigned number or W ID)

Member Name: Last First MI

Health Care Expenses *(continued)*

CLAIM #4

Patient's Name

Patient type (check one): ☐ Myself ☐ My Spouse ☐ My Dependent

Start Date of Service (MM/DD/YYYY) **End Date of Service** (MM/DD/YYYY)

Expense type (check one): ☐ Deductible ☐ Medical ☐ Dental ☐ Vision ☐ Prescription (Rx) ☐ Over-the-Counter (OTC) ☐ Orthodontia

Amount

CLAIM #5

Patient's Name

Patient type (check one): ☐ Myself ☐ My Spouse ☐ My Dependent

Start Date of Service (MM/DD/YYYY) **End Date of Service** (MM/DD/YYYY)

Expense type (check one): ☐ Deductible ☐ Medical ☐ Dental ☐ Vision ☐ Prescription (Rx) ☐ Over-the-Counter (OTC) ☐ Orthodontia

Amount

TOTAL AMOUNT– This is the total of the five health care claims listed above.

**If more lines are needed, please complete another form. You can get claim forms at payflexwallet.com under Resources, select My Plan's Forms and Documents. Attach the appropriate documentation for each claim.

Dependent Care Expenses (Child or Adult)

If your caregiver completes the "Caregive Certification" section of this form, you don't need to send supporting documents. If you're submitting an eligible claim for multiple dependents, you must list each dependent in a separate section below.

Complete this section to request reimbursement. Information provided below must match your support documents.

CLAIM #1:

Qualifying Person's (Dependent's) First & Last Name **Age** (on service date)

Start Date of Service (MM/DD/YYYY) **End Date of Service** (MM/DD/YYYY)

Amount

☐ Dependent is under age 13 OR is mentally or physically incapable of self-care due to a diagnosed medical condition and is over age 12. ***Please check, if Yes.condition.**

CLAIM #2:

Qualifying Person's (Dependent's) First & Last Name **Age** (on service date)

Start Date of Service (MM/DD/YYYY) **End Date of Service** (MM/DD/YYYY)

Amount

☐ Dependent is under age 13 OR is mentally or physically incapable of self-care due to a diagnosed medical condition and is over age 12. ***Please check, if Yes.condition.**

TOTAL AMOUNT – This is the total of the two dependent care claims listed above.

If more lines are needed, please complete another claim form.

Employee Information

Member ID (Employer assigned number or W ID)

Member Name: Last First MI

Caregiver Information/Certification

My signature certifies that I received payment for providing services for:

Qualifying Person's (Dependent's) First Name

Name (Please print)
Last

First

Relative: ☐ Yes ☐ No

Provider Signature:

Caregiver Information/Certification

My signature certifies that I received payment for providing services for:

Qualifying Person's (Dependent's) First Name

Name (Please print)
Last

First

Relative: ☐ Yes ☐ No

Provider Signature:

(**Note:** This is for a second caregiver, if you have more than one.)

For Health Care Flexible Spending Account: I certify that I, my spouse or eligible dependent have incurred each expense on this form. These expenses are for eligible medical care. They are not for cosmetic reasons. I understand that "incurred" means the service has been provided.

For Dependent Care Flexible Spending Account: I certify that I have incurred the Dependent Care expenses for me and, if married, my spouse to work. These expenses are for my qualified dependent. These qualify as eligible expenses under my plan and are not for educational expenses to attend kindergarten or higher. I understand that "incurred" means the service has been provided. This is regardless of when I am billed or charged for, or pay for the service. I acknowledge that I will have to report the caregiver's name, address and Tax Identification Number on Form 2441.

I have not received reimbursement for any of these expenses. I will not seek reimbursement elsewhere, including from a Health Savings Account (HSA). If I receive reimbursement, I and (if married) my spouse will not claim these same expenses on our income tax return. I have received and read the printed material for the plan. I agree to all of the terms and conditions of the plan. Any person who, knowingly and with intent to defraud, files a statement of claim containing any material false, incomplete or misleading information is guilty of a crime.

Employee Signature	**Date** (MM/DD/YYYY)
✍	☐☐/☐☐/☐☐☐☐

Financial Sanctions Exclusions (Anti-Money Laundering-AML):
PayFlex cannot and shall not provide any payment or service in violation of any United States (US) economic or trade sanctions.

If you are mailing your claim, please keep a copy of this claim form and supporting documentation. We will not return these documents.

Mail this form to: PayFlex Systems USA, Inc, HSA Operations, PO Box 3615, Carol Stream, IL 60132-3615