

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 section containing fields for Member ID, Member Name (Last, First, MI), Member Address (Street, City, State, ZIP Code), and Employer Name.

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

Health Care Expenses section containing three claim entries (CLAIM #1, #2, #3). Each entry includes fields for Patient's Name, Start/End Date of Service, Expense type, and 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 "Caregiver 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 Health Care Flexible Spending Accounts and Health Reimbursement Arrangements: I understand that state laws may prohibit the reimbursement of certain expenses and I certify this reimbursement claim and any related documentation provided complies with my state's law regarding the reimbursement of expenses for certain services.

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