PAYFLEX®

Health Reimbursement Account (HRA)

Mail or Fax completed form and documentation to:
PayFlex Systems USA, Inc.
PO Box 4000
Richmond, KY 40476-4000
Fax: 1-888-238-3539
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For the hearing impaired, call 1-877-703-5572

To help 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 or by using the PayFlex Mobile® app?
Log in to your member website or mobile app to get started. You can also find instructions online for completing this form.

Member Identification Number *(Employer/Member assigned number or W ID)*

Member Full Name *(Last Name, 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 eligible dependents)

☐ **Automatic Monthly Reimbursement for Orthodontia expenses:** To set up automatic reimbursements, check this box. Include a copy of your orthodontia contract with this form. **Note**: For automatic monthly reimbursements, you only need to send this form and the contract once.

Patient Name	Type of Service (deductible, dental, medical, orthodontia, over the counter, pharmacy, vision)	From Date of Service (not payment date) MM/DD/YYYY	To/Thru Date of Service (not payment date) MM/DD/YYYY	Amount Requested	Limited Purpose HRA Post deductible **Have you met your health plan deductible?** If Yes, EOB must be provided.
				$	☐ Yes ☐ No
				$	☐ Yes ☐ No
				$	☐ Yes ☐ No
				$	☐ Yes ☐ No
				$	☐ Yes ☐ No
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				$	☐ Yes ☐ No
**If more lines are needed, please complete another form.			Total	$ **0**	

For Health Reimbursement Arrangement (HRA) members: I understand that an Internal Revenue Service (IRS) rule only lets me use my HRA for eligible individuals if they're covered by a compliant group health plan*. I certify that the patient noted on my claim (myself, spouse, or eligible dependent) is covered under my Employer's group health plan or another compliant group health plan*. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions. *The group health plan must be compliant with the Affordable Care Act (ACA). It can't have annual or lifetime dollar limits on essential health benefits. And it can't exclude coverage because of pre-existing conditions.

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 that the service has been provided. This is regardless of when I am billed, charged for or pay for the service. 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 materials 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.

Member Signature

Date

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

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