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Claim Form Instructions

Get your money fast in three easy steps:

1) Fill out the claim form completely and check to make sure your supporting documentation is complete and accurate. It should include:

- Description of Service
- Date of Service
- Amount owed (after insurance has paid its portion)

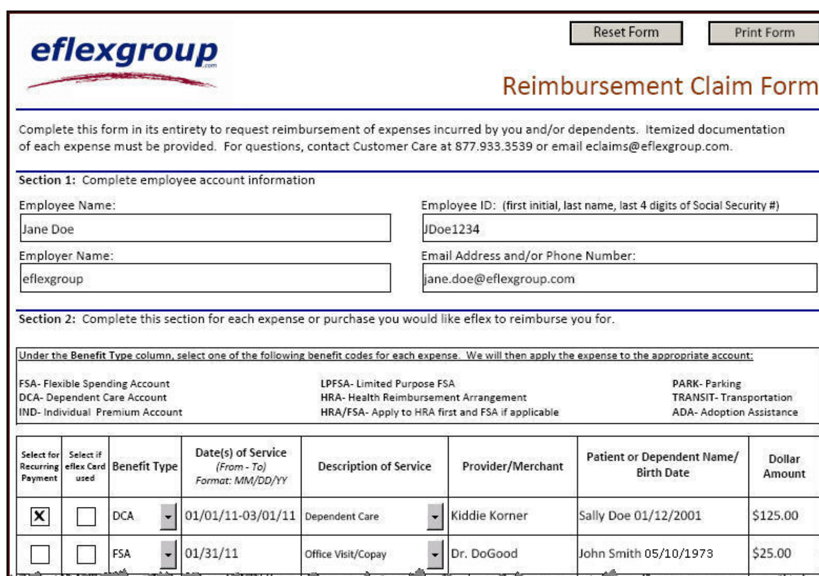
2) Sign and date your form.

3) Fax your claim with supporting documents to 877.231.1287 or mail to our address below.

Helpful Hints to get your claim paid even FASTER!

- The fastest way to get reimbursed is to file your claim online. It's simple and takes less than 5 minutes to file and upload your receipt. Go to eflexgroup.com and click **File A Claim,** then **File Online** to get started.
- If you'd like to be reimbursed for on-going Dependent Care, Orthodontia or Individual Premium expenses, fill out this claim form and select the **Recurring Payment** box. With proper documentation, you only file once but continue to be reimbursed throughout the year.
- Did you pay for your expense with your eflex Card? Don't forget to select **Paid with eflex Card** on the claim form.
- Enroll in Direct Deposit. It's the fastest, greenest and most reliable way to get your money back (Form available online).

Claim and Documentation Examples



Reset Form | Print Form

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Reimbursement Claim Form

Complete this form in its entirety to request reimbursement of expenses incurred by you and/or dependents. Itemized documentation of each expense must be provided. For questions, contact Customer Care at 877.933.3539 or email eclaims@eflexgroup.com.

Section 1: Complete employee account information

Employee Name: Jane Doe

Employee ID: (first initial, last name, last 4 digits of Social Security #) JDoe1234

Employer Name: eflexgroup

Email Address and/or Phone Number: jane.doe@eflexgroup.com

Section 2: Complete this section for each expense or purchase you would like eflex to reimburse you for.

Under the Benefit Type column, select one of the following benefit codes for each expense. We will then apply the expense to the appropriate account:

FSA- Flexible Spending Account
DCA- Dependent Care Account
IND- Individual Premium Account
LPFSA- Limited Purpose FSA
HRA- Health Reimbursement Arrangement
HRA/FSA- Apply to HRA first and FSA if applicable
PARK- Parking
TRANSIT- Transportation
ADA- Adoption Assistance

Select for Recurring Payment	Select if eflex Card used	Benefit Type	Date(s) of Service (From - To) Format: MM/DD/YY	Description of Service	Provider/Merchant	Patient or Dependent Name/ Birth Date	Dollar Amount
☒	☐	DCA	01/01/11-03/01/11	Dependent Care	Kiddie Korner	Sally Doe 01/12/2001	$125.00
☐	☐	FSA	01/31/11	Office Visit/Copay	Dr. DoGood	John Smith 05/10/1973	$25.00

CREDIT CARD RECEIPT		Payer Name: Kiddie Corner
DATE	Charge	AMOUNT
1/01/11–3/01/11	Card # 123456•••	$125.00
	No Description of Service	
	TOTAL	$125.00

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F: 877.231.1287 · E: eclaims@eflexgroup.com

Reimbursement Claim Form

Please complete this form to request reimbursement of expenses incurred by you and/or eligible dependents. Itemized documentation of each expense must be provided. For questions, contact Customer Care at 877.933.3539 or email eclaims@eflexgroup.com.

Section 1: Complete employee account information.

Employee Name:

Employee ID: (first initial, last name, last 4 digits of Social Security #)

Employer Name:

Email Address and/or Phone Number:

Section 2: Please list each eligible expense below.

Under the **Benefit Type** column, select one of the following benefit codes for each expense. We will then apply the expense to the appropriate account:

FSA - Flexible Spending Account
DCA - Dependent Care Account
PRA - Premium Reimbursement Account
LPFSA - Limited Purpose FSA
HRA - Health Reimbursement Arrangement
HRA/FSA - Apply to HRA first and FSA if applicable
PARK - Parking
TRANSIT - Transportation
ADA - Adoption Assistance

Recurring Payment	Paid with eflex Card	Benefit Type	Date(s) of Service *(From - To) Format: MM/DD/YY*	Description of Service	Provider/Merchant	Patient or Dependent Name & Birth Date	Dollar Amount
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
						Claim Total	

Section 3: Please sign, date and fax the completed form to 877.231.1287 or email to eclaims@eflexgroup.com.

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my reimbursement plans. I or (we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return. Any person, who knowingly and with intent to injure, defraud or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law. Where indicated, parking amounts claimed are without an available receipt and this certification includes such expenses.

Signature:

Date: