PAYFLEX®

Flexible Spending Account (FSA) / Limited Purpose Flexible Spending Account (LPFSA) Claim Form

Mail or Fax completed form and documentation to:
PayFlex Systems USA, Inc.
PO Box 2495
Omaha, NE 68103
Fax: 1-888-238-3539
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1-888-678-8242 (TTY: 711)

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?

To get started, log in to the PayFlex Mobile app or your PayFlex member website. You can also find instructions online for completing this form.

Member Identification Number *(Employer 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 FSA Post deductible **Have you met your health plan deductible?** If Yes, EOB must be provided.
				$	☐ Yes ☐ No
				$	☐ Yes ☐ No
				$	☐ Yes ☐ No
				$	☐ Yes ☐ No
****If more lines are needed, please complete another form.**			**Total**	**$** 0	

Dependent Care Expenses (Child or Adult)

If your caregiver completes and signs below, you do not need to include an itemized statement.
If requesting for multiple dependents, each dependent must be listed on a separate line.

Exact Dates of Service					
From MM/DD/YYYY	**To** MM/DD/YYYY	**Amount Requested**	**Qualifying Person's (Dependent's) First and Last Name** (Please Print)	**Age** On Service Date	Qualifying person (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.**
		$			☐ Yes
		$			☐ Yes
		$			☐ Yes
		$			☐ Yes
Total		**$** 0	***You do not need to submit evidence of diagnosed medical condition.**		

Caregiver Information/Certification

My signature certifies that I have provided the services for these expenses for _____
(Qualifying Person's (Dependent's) First Name)

Name *(Must be printed)* _____

Relative: ☐ Yes ☐ No

Provider Signature _____

Caregiver Information/Certification

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

My signature certifies that I have provided the services for these expenses for _____
(Qualifying Person's (Dependent's) First Name)

Name *(Must be printed)* _____

Relative: ☐ Yes ☐ No

Provider Signature _____

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: 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 or attend school. These expenses are for my Qualified Person (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. These are 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 Internal Revenue Service 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 FSA or Limited FSA 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.