



Employer _____
Employee _____
Social Security # _____
Phone _____
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Medical Expense Claims (FSA, Employer funded HRA or HSA)

Account Type FSA HRA HSA	Date Expense Incurred	Provider Name (Physician, Hospital, Dentist, Pharmacy, etc)	Service Provided (Co-Pay, Deductible, Dental, Vision, RX, over-the-counter, etc.)	Amount Requested
Total Amount Requested				0.00

Dependent Day Care Claims

Dependent Name	Date of Service From To	Provider Name	Provider Tax ID #	Type of Service (Day Care, Pre-K, Day Camp, etc.)	Amount Requested
Provider Signature or Stamp _____ (if no receipt is available)					Total Amount Requested 0.00

Commuter/Transportation Expense Claims

Expense Type Parking Transit	Date(s) of Service From To	Provider Name (Transit or Parking Provider Name)	Description of Expense (Mass Transit, Train, Van Pool, Parking, Bus, Commuter, etc)	Amount Requested
Total Amount Requested				0.00

To avoid delays in reimbursement, please sign and date this claim form and provide notice of any name or address change to AmeriFlex.

I authorize my account(s) to be reduced by the amount requested. To the best of my knowledge and belief, the statements on this form are complete and true. I am claiming reimbursement only for eligible expenses incurred by eligible plan participants during the applicable plan year. I certify that these expenses have not been previously reimbursed by this or any other benefit plan, will not be reimbursed from any other source and will not be claimed as an income tax deduction.

Employee Signature: _____ Date: _____

Mail Claim to: AmeriFlex
700 East Gate Drive, Suite 510
Mount Laurel, NJ 08054
Attention: Claims Department

Fax Claim to: 856.631.1020
Attention: Claims Department

Email Claim to: service@flex125.com



INSTRUCTIONS AND INFORMATION FOR COMPLETING YOUR CLAIM

Please read these instructions and be sure your claim is completed in its entirety to insure there is no delay in processing.

Instructions

1. Complete the employee information section.
2. Complete each section (Medical, Dependent, Commuter) as appropriate. Services must be incurred to be reimbursed.
3. Attach all required documentation.
4. Sign and date the claim form (NOTE: If the form is submitted without a valid signature, the claim will be denied)
5. Make copies of the form for your records.
6. Mail, fax or email the completed claim form to AmeriFlex. If emailing, be sure to scan your "signed" claim form and attach scanned documentation.
7. If you have questions regarding your reimbursement account, claim, or eligible expenses, please contact Customer Service at 888-868-3539 or visit our website at www.flex125.com.
8. Please allow 2 -3 weeks for paper check delivery and 5-7 days from the date of processing for direct deposits.

FSA/HRA/HSA Expenses

Please refer to the Quick Reference Guides on AmeriFlex's website for specific information about how these plans work.

Please reference the Eligible Expense Guide on AmeriFlex's website for a list of items eligible for reimbursement.

Acceptable forms of documentation include:

- **Explanation of Benefits (EOB):** This is the form you receive each time you submit claims for payment to your health, dental, or vision care plan indicating the amount you still owe.
- **Receipts** which include the name of person for whom the service/supply was provided; date the expense was incurred; type of service; name of provider; and amount of expense.
- **Note:** the IRS does not allow credit card receipts/statements as eligible proof of expense.
- **HSA expenses** do not require submission of receipts.

If you participate in both an FSA and an HRA, funds will be deducted from each account based on the plan design selected by your employer. If your HRA requires that you first meet your healthcare deductible before funds are available, you must submit an HRA Activation form to AmeriFlex once your deductible has been met in order for the HRA fund to be activated on your AmeriFlex Convenience Card

Orthodontia expenses: depending on how your FSA is designed, your plan may reimburse advanced or "up-front" expenses for orthodontia made through a payment plan or it may reimburse only after the expense has been incurred and services rendered. Please contact your employer to see how your plan reimburses participants for orthodontic care. Prepaid expenses are subject to proof of payment, (i.e., cancelled check, bill from provider indicating payments or credit card receipt) and require that a copy of the orthodontia treatment contract, including total fee, down payment, monthly fees and the estimated length of treatment, must be submitted with the initial claim.

Dependent Day Care Expenses

Dependent Day Care is reimbursed after the service is provided, not when the bill is paid.

Acceptable forms of documentation include:

- **Receipts** which include the name of the person for whom the service was provided, date expense was incurred, type of service, name of provider, the amount charged and the providers tax id number/social security number. If you are using a private provider (i.e. babysitter) the receipt must include their full name, signature, address and social security number, in addition to the above information.
- **Note:** the IRS does not allow credit card receipts/statements as eligible proof of expense

Commuter/Transportation Expenses

IRS regulations do not permit reimbursement for expenses older than 180 days from the date incurred.