PrimePay®

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PrimeFlex: Form #21 – Medical FSA, Dependent Care FSA & Health Reimbursement Arrangement Claim Form

PLEASE COMPLETE THIS FORM AND FAX IT – ALONG WITH COPIES OF YOUR EOB and/or RECEIPTS – TO PRIMEFLEX AT 877.6FAX.HRA.

Employee Information (Please print clearly) ☐ **PLEASE CHECK HERE IF THIS IS AN ADDRESS CHANGE**

Name: (Last, First, Middle)		Social Security Number:	Date of Birth:
Street:	City:	State:	Zip Code:
Employer:			Work Telephone Number:
E-mail:			Home Telephone Number:

☐ **PLEASE ISSUE PAYMENT DIRECTLY TO THE MEDICAL PROVIDER(S) OF SERVICE LISTED BELOW. I CONFIRM THAT I HAVE COMPLETED & ATTACHED THE PROVIDER PAY FORM OR INCLUDED THE MEDICAL INVOICE FOR EACH PROVIDER REQUIRING DIRECT PAYMENT FROM PRIMEFLEX.**

Eligible Expenses To Be Reimbursed - Please list only expenses that are eligible for this plan. Attach copies of receipts and/or EOBs (on a separate piece of paper) supporting each expense item listed below.

Type of Claim: HRA, FSA, DCA	Description of Expense	Family Member	Date Incurred	Amount of Claim
			Total amount this claim	**$**

READ CAREFULLY!

The undersigned participant in the plan certifies that all expenses, for which reimbursement or payment is claimed by submission of this form, were incurred while the undersigned was covered under the Plan with respect to such expenses. IRS regards the date incurred as being when the service is rendered, not when you actually pay the bill. The undersigned participant also certifies that amounts claimed are not eligible for payment under any other health care plan or program, federal, state or governmental program, workers' compensation, or any other policy of health insurance. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and validity of all information relating to this claim which is provided by the undersigned. The undersigned further understands that no medical expense tax deduction is permitted for amounts for which reimbursement is made.

Employee Signature: _____ **Date:** ____/____/____

Retain the original receipts and a copy of this form for your records. **For Tax Purposes** – Use only for expenses incurred in the same plan year for yourself or members of your family who are dependents.