PAYFLEX®

Health Reimbursement Arrangement (HRA) 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
Page 1 of _____
Call: 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/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)

Patient Name	**Type of Service** (Medical, over the counter, pharmacy)	**From Date of Service** (not payment date) MM/DD/YYYY	**To/Thru Date of Service** (not payment date) MM/DD/YYYY	**Amount Requested**
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
			Total	**$** 0

****If more lines are needed, please complete another form.**

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, over the counter or pharmacy. They are not for cosmetic reasons. I understand that "incurred" means that the service has been provided. It does not mean when I am billed, charged or pay for the expense. I have not received reimbursement for any of these expenses. I will not seek reimbursement elsewhere. 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.

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.

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.******