

Mail claims to FlexAmerica, Inc.,
 Attn: BlueFund Department
 13511 Label Lane, Suite 201,
 Hagerstown, MD 21740
Fax claims to 301.564.5192



-DO NOT USE A FAX COVER PAGE-
 DATE: _____
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Claim Form

For your FSA your balance please log onto www.flexamerica.com

Claim Filing & Documentation Instructions

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| 1) Please sign claim form, include your email address and provide complete documentation for requested information. Claims received on Tuesday, will be mailed on Thursday.
2) Attach an Explanation of Benefits (EOB) or itemized bill from the provider showing the provider name, expense description, date of service, amount paid and, if applicable, amount covered by insurance. Credit card receipts, cancelled checks, and cash register receipts are not acceptable. | 3) Enter Dependent Care reimbursement requests in the appropriate space provided below.
4) Submit pharmacy receipts showing date of service, prescription (Rx) name and number and total amount.
5) "New" Cash register receipts for over the counter expenses are acceptable. |
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Company Name (REQUIRED)	Check ONE (REQUIRED): <input type="checkbox"/> NEW claim <input type="checkbox"/> Resubmitted claim
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Employee Name (REQUIRED)	Daytime Phone Number	Social Security Number
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Street Address: _____ City _____ State _____ ZIP Code _____
****To update your mailing address please see your employer**

Email Address _____

***Please Note* If you are submitting Debit Card verification receipts, please do not use this form. All Debit Card verification forms are available on www.carefirst.com.**

Flexible Spending Account Reimbursement (Enter the following information for EACH attached receipt)

Do not use this area to enter dependent day care claims.

Account Type (Healthcare, HRA, LPF, Premium Reimbursement, etc.)	Dates of Service (from / to)	Reimbursement Amount Requested	Provider Name	Type of Service or Prescription (Rx) Number	Family Member Name, if applicable

ENTER TOTAL: _____

Dependent Care Spending Account Reimbursement (enter the following information for ALL attached receipts)

Use this space for dependent day care expenses only	Dependent Care Expense Total Amount	Provider's Signature (required if receipt is not provided)	Provider Tax ID or Social Security Number
	Date(s) of Service	Provider's Address	Age of Dependent(s) at time of service

I certify that these expenses for which reimbursement is claimed have been incurred by me and/or my eligible dependents and are not payable by any other plan and will not be deducted on my federal, state or local income tax returns.

Employee Certification	Employee Signature (REQUIRED)	DATE
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Comments on your claims: