Mail claims to FlexAmerica, Inc.,
13511 Label Lane, Suite 201,
Hagerstown, MD 21740
Fax claims to 301.564.5191(DC METRO)
OR Toll-Free Fax 888-728-3250

FlexAmerica

Claim Form

-DO NOT USE A FAX COVER PAGE-

DATE: _____

OF PAGES: _____

Find your account balance at www.flexamerica.com

Claim Filing & Documentation Instructions

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.

Company Name **(REQUIRED)**

Check ONE **(REQUIRED)**: ☐ NEW claim ☐ Resubmitted claim

Employee Name **(REQUIRED)**	Daytime Phone Number	Social Security Number

Street Address: _____ City _____ State _____ ZIP Code _____

To update your mailing address please log onto www.flexamerica.com or contact us at 301-530-9400 Email Address_____

***Please Note* If you are submitting Debit Card verification receipts, please use the Flex MasterCard Claim Form available on our website.** http://www.flexamerica.com/flex/pdf/claim_fsa_debit.pdf

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, Parking, Transit, HRA, HSA, 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

Employee Certification	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 Signature** (**REQUIRED**) **DATE**

Comments on your claims: