FlexibleBenefit ADMINISTRATORS

Ph: 800-437-FLEX or 757-340-4567
P.O.Box 8188 • Virginia Beach, VA 23450
www.flex-admin.com

FSA Medical Reimbursement Claim Form

How to File

Form can be submitted by (1) e-mail, (2) fax or (3) mail.

Print Form

☐ Check box if this is to offset previously submitted ineligible expense(s).

To submit by e-mail, Print Form and sign. E-mail form along with documentation to flexdivision@flex-admin.com

To submit by fax, Print Form and fax to: 757-431-1155

To submit by mail, Print Form and mail to: Flexible Benefit Administrators, Inc.
P.O.Box. 8188, Virginia Beach, VA 23450

Account Holder Information

Employee Name (Print name)

Social Security Number or Employee ID #

E-Mail address
(For Notification of Processed Claims, Reimbursement & Account Status)

Employer

Claims For Out-Of-Pocket Expense

INCOMPLETE FIELDS MAY RESULT IN YOUR CLAIM BEING DENIED

-Please indicate your qualifying expenses below. DO NOT include expenses reimbursed by any other source.
-Attach copies of bills, receipts, Explanation of Benefits (EOBs) or other claim documentation. Documentation below must include dates of service, description of service and the expense amount. Cancelled checks and/or credit card statements/receipts are NOT sufficient proof of your claim.
-Be sure to keep your original receipts, bills, etc. for your records.

	Person treated and Relationship	Type of Eligible Expense	Date of Treatment	$ Amount of Expense
1				$ 0
2				$ 0
3				$ 0
4				$ 0
5				$ 0
6				$ 0

Note: Orthodontia expenses are reimbursed as designated by the provider. We must have a copy of your orthodontic contract on file.

Total $ 0

YOU MUST ATTACH APPROPRIATE PROOF OF SERVICE FOR EACH AMOUNT ABOVE.

I request reimbursement from my Health Flexible Spending Account (Health FSA) for the amounts listed above. To the best of my knowledge, my statements are complete and true. I certify these expenses are not covered or reimbursable from any other source, nor will I seek reimbursement for these expenses from any other source and that the expense is not for cosmetic purposes. I understand that I cannot use expenses reimbursed through the Health FSA account as tax deductions when filing income tax returns. I further certify that the expenses submitted on this claim are for myself and/or my qualified tax dependents for health coverage purposes as defined under the Internal Revenue Code 125.

I, the participant, further certify that the expense(s) noted above have not been previously paid for by use of my Benefits Card.

Employee's Signature:

Date

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