Pay-to-Provider Claim Form

Use this claim form if you would like us to pay your provider directly. Checks will be addressed based on the information provided in Step 3.

Step 1: Claim Information

Today's Date: _____/_____/_____ Number of pages: _____ Plan year beginning for: 20____

☐ New Claim ☐ Resubmission of claim ☐ Response to claim denial

Step 2: Participant Information

*=Required Fields

*Employer Name (Do not abbreviate) Department

*Participant Name (First, MI, Last) *Social Security Number

*Participant Mailing Address ☐ Check here if change of address Email Address (If provided, all notifications will be sent via email)

*City *State *Zip

Step 3: Provider Information

*Provider Name (Do not abbreviate) Account Number

*Provider Mailing Address Mailing Address - Continued

*Provider City *Provider State *Provider Zip

Step 4: Reimbursement Request

☐ Medical Reimbursement Account (FSA)
☐ Dependent Care Reimbursement Account ☐ 105(h) Health Reimbursement Account (HRA)

*Employee, Spouse or Dependent Name	*Amount Requested	*Date of Service	*Type of Service

Please note the following requirements for claims submission:

- Please number each receipt according to its order of appearance on this form.
- Previous balances are **NOT** acceptable.
- IRS guidelines do **NOT** consider cancelled checks as valid documentation.
- All reimbursements will be made payable to the employee.

Total Amount Requested: $_____

Minimum Reimbursement for manual claims: $25

Step 5: Authorization

To the best of my knowledge and belief, my statements in this reimbursement voucher are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed on this or any other benefit plan and WILL NOT BE CLAIMED AS AN INCOME TAX DEDUCTION. I authorize my account be reduced by the amount requested.

SIGNATURE OF PARTICIPANT_____ **DATE** _____

Please fax this completed form to Pro-Flex Administrators, LLC: 716-929-2013 or toll free 1-855-214-8987
or mail to: Pro-Flex Administrators, LLC, 8321 Main Street, Williamsville, NY 14221
Visit our website to access account information at www.proflextpa.com