PRO-FLEX ADMINISTRATORS LLC

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

*Account Number

*Provider Mailing Address

Email Address (If provided, all notifications will be sent via email)

*Provider City

*Provider State

*Provider Zip

Step 4: Reimbursement Request

☐ Medical Reimbursement Account (FSA)
☐ Dependent Care Reimbursement Account
☐ Individual Premium Reimbursement Account
☐ Adoption Assistance Reimbursement Account
☐ 105(h) Health Reimbursement Account (HRA)

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

Total Amount Requested: $____________

<u>Please note the following requirements for claims submission</u>:

- If you have multiple receipts/invoices, please number each receipt according to its order of appearance on this form.
- IRS guidelines do **<u>NOT</u>** consider cancelled checks as valid documentation.
- Previous balances are **<u>NOT</u>** acceptable.
- The minimum reimbursement amount for provider checks is $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