FLEX HRA®

Reimbursement Form

Contact Us Today!
www.myflexinfo.com

Date: _____
Fax- # of Pages: _____

Please follow the steps below to thoroughly and accurately complete this form.

Step 1: Personal Information

Company Name: _____

Employee Name: _____ SSN: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Step 2: HRA Expense Claims

Date of Service (mm/dd/yy)	Name of Provider	Patient Name	Description of Service	Claim Amount
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
			Total:	$

Reimbursement Schedule- Claim reimbursements are distributed twice a month.
If Flex receives claims by 5 p.m. on the 5th/20th of the month, reimbursement reports will be sent to the employer/employee by the 15th/last day of the month.

Step 3: Acknowledgement and Signature

I acknowledge that my statements in this request for reimbursement form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the application plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or other benefit plans and will not be claimed as an income tax deduction. I authorize my Health Reimbursement Account to be reduced by the amount(s) requested.

Employee Signature: _____ Date: _____

Submit a Reimbursement Request in four easy steps…

1. Send us a copy of the Explanation of Benefits (EOB) from your insurance carrier referencing the portion of claims applied to the health plan deductible.
2. Write the total amount for reimbursement in the claim amount column.
3. Attach all documentation pertaining to your claim to this form.
4. Send request for reimbursement via mail, fax - 847-440-9100, or email - claims@flexiblebenefit.com.

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