**MAIL TO:**
**PayFlex Systems USA, Inc.**
**P.O. Box 3039**
**Omaha, NE 68103-3039**
**(800) 284-4885**

HealthHub™ Powered by PayFlex®

Clear Form

# Reimbursement Accounts Claim Form

**FAX TO:**
**PayFlex Systems USA, Inc.**
**(402) 231-4310**
**(No Cover Page Required)**
**Page 1 of _____**

**WAIT! Did you know that you can file this claim online?** Login to www.HealthHub.com and select *File a Claim* under Quick Links.
**Do you need your account balance?** After logging in, access your account balance via *My Dashboard* or the *Financial Center.*

**Employee Name** _____ **Member Number**_____
(This may be your SSN or employer assigned number)

**Employer Name** _____
*Note: To make an address change, please contact your employer's HR/Benefits department. For security purposes, we cannot accept address changes directly.*

## Health Care Claims (For you or your dependents) - For additional information, please visit our website at: www.HealthHub.com.

***Covered by insurance*** - Expenses for services or items must be submitted to your insurance company *before* submitting for reimbursement under your reimbursement account. When you receive the **Explanation of Benefits Statement (EOB)** from your insurance company, include a copy with this completed claim form. If you have a copay, attach an itemized statement from your service provider. Do not submit expenses previously paid for with your PayFlex Card™.

***Not covered by insurance*** - For services or items, submit an itemized statement from the provider showing the provider's name and address, patient name, date the service was provided, a description of the service, and the amount charged along with this completed claim form. Balance forward statements, cancelled checks, credit card receipts or received-on-account statements are not acceptable. Orthodontia claims require an itemized statement/payment receipt, the orthodontist's contract/payment agreement or monthly payment coupons.

***Prescription and over-the-counter*** items require a print-out of prescriptions from your pharmacy or must be clearly identifiable on an itemized receipt. Starting January 1, 2011, OTC drugs and medicines will be considered ineligible unless you have a written prescription from your doctor. This prescription must be submitted with your claim form in order to get reimbursed. Quantities purchased must be reasonably able to be consumed during the current plan year. Items for maintaining general good health, cosmetic purposes and dietary supplements are not eligible.

☐ **Automatic Monthly Reimbursement for Orthodontia expenses.**
To establish automatic reimbursements, check the box and include a copy of your ortho contract when submitting this form to PayFlex for the first time.

| Date of Service | Type of Service (Ex. – Prescription, Over-the-Counter, Vision, Dental, Hearing, Office Visit, etc…) | Amount Requested | Date of Service | Type of Service (Ex. – Prescription, Over-the-Counter, Vision, Dental, Hearing, Office Visit, etc…) | Amount Requested |
|---|---|---|---|---|---|
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| | | | | **Total** | $ 0 |

## Dependent Child or Adult Day Care Claims - For additional information, please visit our website at: www.HealthHub.com.

Complete this form and have your provider sign below **OR** attach an itemized statement from your day care provider . Do **NOT** do both. **IRS regulations allow payment of services for dependents under age 13 or otherwise satisfying the "Qualifying Person Test" as described in IRS Publication 503. Payment is only allowed for services that have already been provided, not for services to be provided in the future.** You are required to report the provider's name, address and Tax Identification Number or Social Security Number on Form 2441 with your personal income tax return. If your day care provider completes and signs this form below, no other itemized statement is necessary.

| Exact Dates of Service | | AGE | Dependent Name | Amount Requested |
|---|---|---|---|---|
| From | To | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | $ 0 |

**Day Care Provider Information:** *My signature certifies that I provided services for the dependent(s) noted above, during the dates specified, and for the amount requested.*

**Name** _____

**Provider Signature** _____

**Day Care Provider Information:** *My signature certifies that I provided services for the dependent(s) noted above, during the dates specified, and for the amount requested.*

**Name** _____

**Provider Signature** _____

I certify that these eligible expenses have been incurred by me, my spouse or eligible dependent and medical expenses are not for cosmetic purposes but for the treatment of an illness, injury, trauma, or medical condition. I certify that Dependent Day Care expenses were incurred in order for me and, if married, my spouse to work and are not for educational expenses to attend kindergarten or higher. I understand that "incurred" means the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed and I will not seek reimbursement elsewhere. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions.

**Employee Signature**_____ **Date** _____

***If you are mailing your claim(s), please keep a copy of your claim form and supporting documentation, as these documents will not be returned.** Rev. 4/2011*