PAYFLEX®

Health Reimbursement Arrangement (HRA) / Retiree Reimbursement Arrangement (RRA) Claim Form

Mail or Fax completed form and documentation to:
PayFlex Systems USA, Inc.
PO Box 981158
El Paso, TX 79998-1158
Fax: 1-855-703-5305

To help avoid claim processing delays, you must sign, date and complete this form. You must also include supporting documentation.
WAIT! Did you know that you can file a claim online or by using the PayFlex Mobile® app?
Log in to your member website or mobile app to get started. You can also find instructions online for completing this form.

Member Identification Number *(Employer/Member assigned number or W ID)*	**Member Full Name** *(Last Name, First, MI)*
Member Address *(Street, City, State, ZIP Code)*	

Note: If you have an address change, please notify your employer. For security purposes, we can only accept an address change from your employer.

Employer Name

Health Care Expenses (For you, your spouse and your eligible dependents)

☐ **Automatic Monthly Reimbursement for Orthodontia expenses:** To set up automatic reimbursements, check this box. Include a copy of your orthodontia contract with this form. **Note**: For automatic monthly reimbursements, you only need to send this form and the contract once.

Patient Name	**Type of Service** (deductible, dental, medical, orthodontia, over the counter, pharmacy, vision)	**From Date of Service** (not payment date) MM/DD/YYYY	**To/Thru Date of Service** (not payment date) MM/DD/YYYY	**Amount Requested**
				$
				$
				$
				$
				$
				$
				$
				$
****If more lines are needed, please complete another form.**			**Total**	**$ 0**

Insurance Premium Expenses

NOTE: For Medicare premiums (deducted from your Social Security check): If this is the first time this calendar year you are requesting reimbursement of premiums, enclose a copy of your "Notice of Medical Insurance Enrollment and Premium Deduction." This is from the Department of Health and Human Services (HHS). After that, you only have to complete this claim form. **Note**: Premiums that you pay pre-tax are not eligible expenses. If this is a request for other insurance premium expenses, enclose a copy of the appropriate supporting documentation.

Covered Eligible Person's Name	**Type of Service** (Premium)	**Type of Premium** (Medicare, Medigap, Medical, Dental, etc.)	**Annual Social Security Administration Letter** If previously submitted, please check Yes	**From Date of Service** MM/DD/YYYY	**To/Thru Date of Service** MM/DD/YYYY	**Amount Requested**
			☐ Yes			$
			☐ Yes			$
			☐ Yes			$
			☐ Yes			$
			☐ Yes			$
			☐ Yes			$
****If more lines are needed, please complete another form.**					**Total**	**$ 0**

I certify that I, my spouse or eligible dependent have incurred each expense on this form. These expenses are for eligible medical care. They are not for cosmetic reasons. If the expense is for insurance premium, I understand that this does not include premiums paid with pre-tax salary reduction. (Premium that is paid pre-tax is not an eligible expense.) I understand that "incurred" means that the service has been provided. This is regardless of when I am billed, charged for or pay for the service. I have not received reimbursement for any of these expenses. I will not seek reimbursement elsewhere, including from a Health Savings Account (HSA). If I receive reimbursement, I and (if married) my spouse will not claim these same expenses on our income tax return. I have received and read the printed materials for the plan. I agree to all of the terms and conditions of the plan. Any person who, knowingly and with intent to defraud, files a statement of claim containing any material false, incomplete or misleading information is guilty of a crime.

Member Signature	**Date**
✍	

******If you are mailing your claim, please keep a copy of this claim form and supporting documentation. We will not return these documents.******