HEALTH CARE FSA
Reimbursement Claim Form

ACCOUNT HOLDER INFORMATION

Last Name

First Name

ID Code (last 4 digits)*

Employer / Program Sponsor's Name

Zip Code

Birth Month/Day (MM/DD)

Email Address (complete only if new)

CERTIFICATION AND AUTHORIZATION

I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible expenses incurred by myself or an eligible dependent while I was a participant in the plan. I have already received these products and services and have not and will not seek reimbursement of this expense from any other plan or party. If I am covered under more than one health care account, reimbursement will be made according to the payment order determined by these plans and as stated on the MyFlexOnline website. If the expense(s) claimed is covered under my Employer's Health Reimbursement Arrangement, I certify that the patient for each claim being submitted is covered under an Affordable Care Act compliant employer-sponsored group medical plan (their own, mine, or my spouse's). Use of this service indicates my acceptance of the Terms of Use agreement (available at https://wageworks.com/terms-of-use).

Employee's Signature

Date

HEALTH CARE ACCOUNT EXPENSE CLAIMS

Date Expense Incurred (mm/dd/yy)	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
Attach appropriate receipt(s) and submit with this claim form.		**Total Health Care Expense Claim**		

*Your ID Code is the last 4 digits of your Social Security Number, your Employee Number or other reference number assigned by your program sponsor. Please check the enrollment instructions provided by your program sponsor for more information about your ID Code.

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Claim Form and Filing Instructions

On the reverse side of this page is a claim form. Please feel free to copy this form.

When filing your claim, you must attach copies of the receipts. The receipt must show the date and type of service for the expense, the provider's name, and the amount of the expense. Canceled checks, credit card slips, or statements showing only a balance due on your account are not allowable.

Please be sure to number each attachment page (e.g., Page 2 of 3, Page 3 of 4, etc.). Your claim form is your cover page. After you fax or mail a claim with receipts, please do not follow up with a claim submitted via any other method.

Fax or mail this form with receipts to:

Fax: (877) 782-8889

Or mail to: FLEX CLAIMS GROUP
claims@takecareclaims.com
P.O. Box 14054
Lexington, KY 40512