

Claim Form Instructions

Complete this form in its entirety to request reimbursement of expenses incurred by you and your dependents. Please provide itemized documentation of each expense.



2740 Ski Lane
Madison, WI. 53713
Phone: (608) 243-8277
Toll free phone: 877-933-3539
Fax: (608) 245-9342
Toll free fax: (877) 231-1287

Helpful Hints to Get Your Claim Paid Fast without Delay

1. Please sign, date and complete required fields outlined in red on your eflex claim form.
2. Fax your claim with supporting documents, toll free at 877-231-1287 or mail to our address above.
3. All receipts, including credit card receipts, should include **description, date of service and amount owed** after the insurance has paid its portion.
4. **For Even Faster Payment**- Fill out, and include our direct deposit form found online at eflexgroup.com for direct deposit into your checking or savings account (optional).
5. Please keep copies for your records.

Claim & Receipt Examples

Reimbursement Claim Form

Complete this form in its entirety to request reimbursement of expenses incurred by you and your dependents. Itemized documentation of each expense must be provided.

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Employee Information (please type or print neatly)

Employee ID: J S M I T H 1 2 3 4 Example: John Smith
Employee ID=First Initial, Last Name (max 8 char), last 4 digits of Social Security # SSN: 564-00-8872
 Employee ID: jsmith8872

Name: J O H N S M I T H

Employer Name: ABC COMPANY Email: jsmith@jsmith.com
Email (if provided) will be preferred method of communication

Check here for new address. Fill out for change of address below.

Address:

City: State: Zip:

Phone #:

Check here if new email address

Benefit Type Codes

F-Health FSA P-Parking
D-Dependent Daycare A-Adoption Assistance
I-Individual Health Premium
H-Health Reimbursement Arrangement (HRA)

<input type="button" value="F"/>	BENEFIT CODE	DATES OF SERVICE FROM (MMDDYY)	AMOUNT REQUESTED	eflex card used for this expense?
		0 1 3 1 1 0	\$ 0 2 5 . 0 0	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
	DESCRIPTION OF SERVICE	TO (MMDDYY)	FAMILY MEMBER'S NAME	Is this a recurring claim?
	Over-the-Counter	0 2 2 8 1 0	John Smith	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <small>If YES, please attach contract</small>

<input type="button" value="D"/>	BENEFIT CODE	DATES OF SERVICE FROM (MMDDYY)	AMOUNT REQUESTED	eflex card used for this expense?
		0 1 0 1 1 0	\$ 1 2 5 . 0 0	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
	DESCRIPTION OF SERVICE	TO (MMDDYY)	FAMILY MEMBER'S NAME	Is this a recurring claim?
	Daycare/Dependent Care	0 3 0 1 1 0	Sally Smith	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <small>If YES, please attach contract</small>

RECEIPT	NO. 52	Payee Name: John Smith	Payer Name: Dr. DoGood
Address: 123 Main St	Address: 987 Doctors Ct.	City, State, ZIP code	City, State, ZIP Code
Anywhere, WI. 51234	Anywhere, WI. 51234		
DATE	DESCRIPTION	AMOUNT	
1/31/10	Office Visit Co-pay	\$25.00	
	TOTAL	\$25.00	

CREDIT CARD RECEIPT	Payer Name: Kiddie Corner	
DATE	Charge	AMOUNT
1/01/10-3/01/10	Card # 123456*** No Description of Service	\$125.00
	TOTAL	\$125.00

Reimbursement Claim Form

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Employee Information (please type or print neatly)

Employee ID

Employee ID=First Initial, Last Name (max 8 char), last 4 digits of Social Security No.

Example: John Smith

SSN: 564-00-8872

Employee ID: jsmith8872

Name

Employer Name

Email

Check here for new address. Fill out for change of address below.

*Email (if provided) will be method of communication
Check here if new email address*

Address

City

State

Zip

Phone #

Benefit Type Codes

FSA-Health FSA

LFSA-Limited Purpose FSA

DCA-Dependent Daycare

PARK-Parking

IND-Individual Health Premium

TRAN-Transportation

HRA-Health Reimbursement Arrangement

ADA-Adoption Assistance

BENEFIT CODE

DATES OF SERVICE
FROM (MMDDYY)

AMOUNT REQUESTED

\$

PURCHASED WITH EFLEX CARD?

YES NO

DESCRIPTION OF SERVICE

TO (MMDDYY)

PATIENT'S NAME

RECURRING CLAIM?

YES NO

If YES, please attach contract

BENEFIT CODE

DATES OF SERVICE
FROM (MMDDYY)

AMOUNT REQUESTED

\$

PURCHASED WITH EFLEX CARD?

YES NO

DESCRIPTION OF SERVICE

TO (MMDDYY)

PATIENT'S NAME

RECURRING CLAIM?

YES NO

If YES, please attach contract

BENEFIT CODE

DATES OF SERVICE
FROM (MMDDYY)

AMOUNT REQUESTED

\$

PURCHASED WITH EFLEX CARD?

YES NO

DESCRIPTION OF SERVICE

TO (MMDDYY)

PATIENT'S NAME

RECURRING CLAIM?

YES NO

If YES, please attach contract

BENEFIT CODE

DATES OF SERVICE
FROM (MMDDYY)

AMOUNT REQUESTED

\$

PURCHASED WITH EFLEX CARD?

YES NO

DESCRIPTION OF SERVICE

TO (MMDDYY)

PATIENT'S NAME

RECURRING CLAIM?

YES NO

If YES, please attach contract

TOTAL \$

***Note* Does your supporting documentation include the service date, service description and charge amount?** YES NO
(Credit card statements don't qualify as documentation according to IRS regulations).

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my reimbursement plans. I or (we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return. Any person, who knowingly and with intent to injure, defraud or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law. Where indicated, parking amounts claimed are without an available receipt and this certification includes such expenses.

Signed By _____

Date