



##13T00026#####

PrimeFlex—(877) 769-3539
Claim Reimbursement Form

Please complete this form and submit it along with all forms of documentation which may include EOB, receipts, and/or proof of payment to PrimeFlex.

Employee Information (Please print clearly) [] PLEASE CHECK HERE IF THIS IS AN ADDRESS CHANGE

Form with fields: Name: (Last, First, Middle), SSN, Date of Birth, Street, City, State, Zip, Employer, Work #, Email, Home #.

Table with 5 columns: Account Type (Ex. HRA, FSA), Description of Expense, Family Member, Dates of Service, Amount of Claim. Includes a Total row and a note: *Please consult your plan documents for a list of eligible expenses.

Form with checkbox: Yes, please issue payment directly to the medical provider(s) of service. I confirm that I have completed the provider pay information below and have included the MEDICAL INVOICE for each provider requiring direct payment from PrimeFlex. All INFORMATION IS REQUIRED. Fields: Medical Provider Name, Provider Address, City, State, Zip, Patient Account Number.

Table for Dependent Care Claims with 5 columns: DCA Provider Name, Tax ID/SSN, Dependent, Dates of Service, Amount. Includes a note: For Dependent Care Claims, please fill in the fields below and: (1) submit an itemized receipt detailing the services, or (2) have the provider sign the line below.

I, as the Dependent Care Provider listed, certify that the above services were provided for the amount listed and during the dates listed.
Dependent Care Provider Signature: _____ Date: ____/____/____

Send this form along with all supporting documentation for each expense item listed above to PrimeFlex in one of the following ways:
For HRA's Only: Fax 877.6FAX.HRA, Email primeflexHRA@primepay.com, Mail Attn: PrimeFlex-HRA Claims, 1487 Dunwoody Drive, West Chester, PA 19380
For All Others: Fax 877.6FAX.FSA, Email primeflex@primepay.com, Mail Attn: PrimeFlex-FSA Claims, 1487 Dunwoody Drive, West Chester, PA 19380

I confirm that I am a participant in the plan(s) for which reimbursement is being requested. I confirm that all claims being reimbursed are for myself and/or a qualified beneficiary in accordance with my enrollment form into the plan. I confirm that all amounts claimed are not eligible for reimbursement/payment under any other plan or program and no medical expense tax deduction may be made on claimed amounts. I confirm that all claims are qualified expenses and that I am fully responsible for the sufficiency, accuracy, and validity of all information relating to above claim(s). I understand that I must retain all receipts for purchases and services rendered, and agree to provide them upon request. I understand that voided checks and credit card statements are not valid proofs of payment. I understand that failure to comply with all of the above requirements may result in a pending or denied claim. I confirm that all of the information is correct.

Employee Signature: _____ Date: ____/____/____