Medical Expense Claim Form

FAX: 1-888-207-2310

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To make a claim for reimbursement of your medical, dental and vision expenses, please complete this form and attach copies of the Explanation of Benefits from your insurer or copies of detailed bills prepared by your care providers. Charge Card receipts are usually not sufficient documentation. Cash register receipts must show detailed information on the services received or items purchased. Detailed pharmacy bills including the name of the medication are required for non-standard co-payment amounts.

Mail your claim and documentation to:

FlexToday, Inc.
PO Box 16099
Fresno, CA 93755

REQUIRED

Employer Name
Employee Name
Address
City, State and Zip Code
Email Address

PLEASE READ & SIGN **I hereby understand, certify and agree that:** The expenses submitted for reimbursement have not been reimbursed or paid previously and I will not seek payment or reimbursement under insurance or other benefit plan for these expenses; These expenses were incurred during the coverage period by either me or my eligible dependents; I assume the responsibility to maintain substantiating documents for all claims; I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim; I am liable for payment of any taxes and penalties, federal, state or local, related to expenses claimed or paid that are not eligible expenses under the Plan(s); These expenses cannot be claimed as credits or deductions on my personal tax return if reimbursed or paid from the Plan(s); Any medically related expenses submitted are to diagnose, alleviate or prevent a medical condition and not merely beneficial to general health; If either my spouse and/or I make or receive contributions to a **Health Savings Account**, my benefits will be considered Limited Purpose and I will only submit claims for qualifying expenses related to preventive care not covered by insurance, vision care or dental care; If the expense(s) claimed is covered under my Employer's **Health Reimbursement Arrangement**, I certify that the patient for each expense being submitted is covered under an Affordable Care Act compliant employer-sponsored group medical plan (their own, mine, or my spouse's); I have received a copy of the Summary Plan Description(s) and understand that this claim is subject to the terms and requirements of the Plan(s), including but not limited to eligibility, coverage period and claims filing deadlines; I may receive notifications by email instead of mail and I understand that I must notify FlexToday in writing to rescind this authorization to send notifications by email; and, My digital signature on this form will be accepted as binding with the same weight and consideration as a pen and paper signature.

Your email address and the answers to the items below are required for us to accept a digital signature on this form.

Last 4 # of EE SSN	Full Date of Birth	Phone Number

Sign Here

Date Signed

Total Medical Expenses Claimed With This Request: $_____

Name of Person Receiving Care	Relationship to Employee	Date service provided	Name of the Care Provider	Type of Service	This is my cost for this service
					$
					$
					$
					$
					$

To protect your privacy and our security, we do not accept claims by email, encrypted or otherwise. You can send claims by fax, mail or electronically (scanned) at the Secure Claims Portal, link in yellow above. You also have the option to use the MyFlex Mobile Application or to upload claims directly into your MyFlexOnline.com account (maximum of 8 line items per claim). Claims sent to the Secure Claims Portal must be identified and sent in Adobe Acrobat or Picture File Formats. Unidentified files and files sent in any format other than Adobe ".pdf" or a picture file format may be unacknowledged and not be treated or considered to be an actual claim submission. Electronic files, links or email attachments received in executable formats (.exe, .zip, .eml, .com, .net, .html, vbs, etc.) will be isolated and then deleted without opening and will not be acknowledged or considered an actual claim submission.