PRIMEPAY®

PrimeFlex—(877) 769-3539

Claim Reimbursement Form

Reset Form | Email Form

##13T00026##########

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**

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

Account Type (Ex. HRA, FSA)	Description of Expense	Family Member	Dates of Service	Amount of Claim
*Please consult your plan documents for a list of eligible expenses.			Total	

☐ **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.**

Medical Provider Name: (Make check payable to)			
Provider Address: Street	City	State	Zip
Patient Account Number:			

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.

DCA Provider Name	Tax ID/SSN	Dependent	Dates of Service		Amount
			From:	To:	
			From:	To:	

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		For All Others
Fax	877.6FAX.HRA	Fax	877.6FAX.FSA
Email	primeflexHRA@primepay.com	Email	primeflex@primepay.com
Mail	Attn: PrimeFlex-HRA Claims 1487 Dunwoody Drive West Chester, PA 19380	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 pended or denied claim. I confirm that all of the information is correct.

Employee Signature: _____ **Date:** ____/____/____