

**Fax-a-Claim: (866) 329-3539 [866-Fax-Flex] or Email to: Flex@ProBenefits.com (PDF only)**  
**Or skip this form and log on to your account at ProBenefits.com to submit online**

\*Employer: \_\_\_\_\_

\*Participant Name: \_\_\_\_\_

Social Sec #: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Mailing Address, if changed: \_\_\_\_\_

Email Address: \_\_\_\_\_

*Used to send you a confirmation after your claim is processed*

Paid with Flex Card?	Provider Name	Description of Expense (Ex: Rx, Office Visit, Deductible, Daycare)	Type of Expense			*Dates of Service		*Amount of Expense
			Med HRA	Med FSA	Dep Care	Begin	End	
<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	___/___/___	\$
<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	___/___/___	\$
<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	___/___/___	\$
<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	___/___/___	\$
<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	___/___/___	\$
If you have more expenses, please list them on a separate page, and include the full total amount of your claim here. <b>*Total:</b>								\$

**Comments:** \_\_\_\_\_

**Important Notes:**

- Please submit documentation for all expenses claimed on this form. Per IRS Regulations, all claims must be adjudicated based on provider receipt(s) indicating the following: Dates of Service & Amount of Expense; Type of Service (e.g., Office Visit, Rx, Childcare); and Name of Provider (e.g., Doctor, Hospital, Childcare Giver). **For an HRA claim, in most cases an EOB is required.**
- Non-itemized credit/debit card slips or cancelled checks will not be accepted as valid documentation for any claim.
- For Dependent Care, per IRS regulations:
  - Eligible expenses are for custodial care for children age 12 and under or for dependent, disabled adults.
  - IRS requires that the name, address, and tax ID number of your childcare provider be given. If not included on your receipt, please include in Comments above.
- The method of reimbursement for your claim will be determined by the information on file in your account. To view or change your reimbursement information, please log in at [www.ProBenefits.com](http://www.ProBenefits.com).
- If you email your claim, please use only PDF format for your file attachment. Other formats cannot be accepted.
- **If your claim is an HRA, any portion not reimbursed by your HRA account will be applied to your ProBenefits Health FSA, if you have one.**

**Certification:** These expenses were incurred (have a date of service) by me and/or my spouse or eligible dependents during the plan year while I have been a covered participant and to the best of my knowledge are reimbursable by the plan. I, the participant, certify that I have not been reimbursed for the above expense(s) and that I will not seek reimbursement under any other plan covering health benefits, such as my spouse's health plan. I understand that any expense reimbursed under this Plan may not be used to claim any income tax deduction or credit. I also understand that privacy regulations prohibit ProBenefits from discussing claims with anyone other than the participant.

\*Signature \_\_\_\_\_ \*Date \_\_\_\_\_

*\*All items marked are required for processing.*