



**FLEX-PAY BUSINESS SERVICES, INC.**

**HRA REIMBURSEMENT CLAIM**

**Fax To: (336) 245-2291**

**Total # Pages Sent:** \_\_\_\_\_

Participant Name \_\_\_\_\_

Social Security # \_\_\_\_\_ Day Phone (\_\_\_\_) \_\_\_\_\_

Employer Name: \_\_\_\_\_ Email Address \_\_\_\_\_

Address, if Changed \_\_\_\_\_

**REQUEST FOR REIMBURSEMENT:**

**Important** – In order to receive reimbursement, you must attach copies of the **Explanation of Benefits (EOB)** provided by your insurance company.

Date From \_\_\_\_/\_\_\_\_/\_\_\_\_ Date To \_\_\_\_/\_\_\_\_/\_\_\_\_ Amount: \$\_\_\_\_\_

**DIRECT DEPOSIT OPTION:**

*Please attach a Voided Check (not deposit slip)*

**By attaching a voided check, I hereby acknowledge the following:**

I hereby authorize **Flex-Pay** (hereinafter *Plan Service Provider*) to initiate credit entries (electronic and otherwise) and, if necessary, debit entries and adjustments for any erroneous credit entries posted to my Personal Bank Account.

**CERTIFICATION:**

These expenses were incurred (have a date of service) during the Plan year while I have been a covered participant in the Plan. I certify that these expenses were incurred for me and they have not and will not be reimbursed from any other health insurance coverage. I understand that I alone am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by me; and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense. I also understand that privacy regulations prohibit **Flex-Pay** from discussing claims with anyone other than the participant.

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

**Dated** \_\_\_\_\_