

Claim Form

Total # Pages Sent

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

*Employer _____

*Employee Name _____ Last four digits of Social Security Number _____

Mailing Address, if changed _____

Email (to receive confirmation of claim entry) _____ Daytime Phone _____

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	TRA/Park	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"/>	___/___/___	___/___/___	\$
<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. ***Total: \$** _____

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.
- 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 (if applicable to your plan).
- 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.
- If you email your claim, please use only PDF format for your file attachment. Other formats cannot be accepted
- Log in to ProBenefits.com to check claim status, view account details, submit claims and more..

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.*



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