BeneFlex

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Email submission to: claims@flexaccount.com or Fax: (732) 428-8111

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) ACCOUNT CLAIM FORM

Indicate Payee: ❑ Pay Participant ❑ Pay Service Provider (pay only one per form)

Part I: Participant Information

Company Name:
Participant Social Security Number:
Participant Name (Last/First/MI):
Participant E-mail:
Participant Daytime Phone Number:

Part II: Provider Information

Provider Name:	
Provider Address:	
Provider City, State and Zip Code:	
Provider Telephone	**Provider Taxpayer Identification Number (EIN):**

****Explanation of Benefits (EOB) Must Accompany This Request !!!!**
****All Provider Fields Listed Above Must Be Completed**

Part III: Medical Reimbursement Request

IRS regulations mandate that beginning January 1, 2011 Over-the-Counter (OTC)Medicines/Drugs require a doctor's prescription. Please attach.

	Dates of Service Beginning Date to Ending Date		Primary or Dependent and Relationship	Expense Description	Reimbursement Requested
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
	**Total Reimbursement Requested >>>>