Customer Service Phone: (800) 659-3035	Claims Submission Fax: (877) 879-9038
Customer Service Email: asi@asiflex.com	Customer Service Website: www.asiflex.com
Online Claims Submission: https://my.asiflex.com *Emailed claims will not be accepted.*	Claims Mailing Address: P.O. Box 6044 Columbia, MO 65205

Claim Filing Requirements

(This page is for your assistance only, it does not need to be submitted to ASIFlex with your claims submission)

Go Paperless by enrolling for email notification and claims reimbursement via direct deposit! See details below.

Claim Filing Guidelines Checklist:

☐ Clearly print your name, address, social security number (or EID as appropriate) and your employer's name
☐ List expenses and arrange the supporting documentation in the same order
☐ Enclose required documentation

IRS Documentation Requirements:

Each item claimed must be supported with proper documentation. The documentation must include each of the following five (5) essential pieces of information, otherwise your claim will not be processed. The following should be included with each piece of documentation submitted to ASIFlex with your completed claim form:

1. *Name of the provider or merchant (medical or dependent care)*
2. *Name of the person, or persons receiving the service or care*
3. *Date or range of dates of service or care*
4. *Cost of the service, not just the amount paid*
5. *Description of the service or care*
   - ✓ *Without a description of the service or care provided, your claim will be denied.* ***Credit card receipts, cancelled checks and billing statements without detailed service information are not substantial documentation and will not be accepted.*** *The description of the service or care can be as generic as "copay" or "office visit". If the description of the service is not listed on the receipt provided from your service or care provider, the provider may write the description on the receipt.*

**Please note if a receipt is not available for dependent/elder care expenses, you may have the care provider sign and date in place of a receipt.*

☐ **Sign** the claim form. (Claim forms that are not signed will not be accepted)
☐ Keep copies of each receipt and claim form for tax purposes (Dependent/Elder Care FSA participants must file IRS Form 2441 each year with tax return). Keep in mind that you will need the provider's tax ID or Social Security Number when you file your taxes.
☐ Submit completed claim form and supporting documentation to ASIFlex

Claim Submission Options:

- *Online*
  - *https://my.asiflex.com*
    Submitting your claim online is easy and convenient! In order to submit your claim via ASIFlex's secure online portal, you will need your PIN, which was provided to you in your welcome packet and in each account summary statement. If you do not have your PIN, you may call Customer Service at (800) 659-3035.
- *Toll-free fax*
  - *(877) 879-9038*
    This option provides easy and fast claims submission. You may submit your claim via ASIFlex's toll-free fax number 24 hours a day, 7 days a week.
- *US Mail*
  - *P.O. Box 6044, Columbia, MO 65205*

- ***Go Paperless!*** Sign up to receive notifications from ASIFlex via email, rather than US Mail. By signing up for email notification, you will receive reimbursement notifications, account summary statements and more within one day of processing. Online Account Detail and the Secure Message Center are available 24 hours a day, 7 days a week at https://my.asiflex.com. Complete history, including available funds, year-to-date contributions, year-to-date reimbursements and more are available at online account detail. You will need your Flexible Spending Account PIN in order to access https://my.asiflex.com. Your PIN was provided to you in your welcome packet. If you do not have your PIN, you may call Customer Service at (800) 659-3035 to obtain this number.
- Sign up for **direct deposit** today! By electing to receive reimbursements via direct deposit, you will **receive your money up to 5 days faster** than waiting for a check to be mailed to your home address. Direct deposit enrollment forms can be found at www.asiflex.com, or by calling customer service.
- Additional claim forms may be obtained by visiting www.asiflex.com.
- Find an extensive list of eligible and ineligible expenses online at www.asiflex.com Refer to your plan's Summary Plan Description or Enrollment Guide for specifics regarding orthodontia and other plan specific restrictions regarding reimbursement.

Submit your claim online!
https://my.asiflex.com
You will need your PIN to submit your claim online. If you don't have your PIN, call ASIFlex at (800) 659-3035.

Claim Form

Please print clearly

Go Paperless!
Sign up to receive communication from ASIFlex via email rather than US Mail. Complete the email notification form at www.asiflex.com.

Name (Last, First, MI)	Social Security Number *or* EID *or* PIN	Employer	
		State of Delaware	
Mailing Address	**City**	**State**	**ZIP Code**

Dependent Care Flexible Spending Account

Dependent care expenses must be for a dependent who is incapable of self care or under the age of 13 at the time the care was provided.

Name of Dependent	Age	Dates Care Provided		Name and Address of Care Provider	Cost for Care Period
		From	To*		
				Total Dependent Care Amount Requested	

I provided the dependent care as stated above. _____ _____
Dependent Care Provider's **original** signature Date

Claims for future services are **not eligible for reimbursement and will not be processed.*

Health Care Flexible Spending Account

Date Medical Care **Provided***	Name of Medical Provider	General Medical Expense	Name of person receiving service/care	Relationship	Dollar amount that is your responsibility
				Total Health Care Amount Requested	

As a participant of the Plan, I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while I was covered under my employer's Flexible Spending Plan and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. Any claimed Dependent Care Assistance expenses were provided for my dependent under the age of 13 or for my dependent who is incapable of self care. I fully understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim, 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 local income tax on amounts paid from the Plan which relate to such expense.

_____ _____
Employee's Signature Date

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Resources

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