Instructions

1. Employee must complete **Employee Information.**

2. Complete **Claim Information** in its entirety. Please ensure your supporting documentation clearly indicates the requested amount.

3. Check the appropriate box in Supporting Documentation section and attach Acceptable Supporting Documentation as described below. (When attaching small receipts, we suggest you tape them to a standard size sheet of paper.)

   a) Itemized statement or bill from your provider including:
   - Provider name
   - Patient name
   - Description of service
   - Original date of service (the date of service, not the date of payment must fall within the plan year for which you are enrolled and while you are a participant in the plan)
   - Patient portion of charge(s); or

   b) Explanation of Benefits (EOB) from your insurance carrier; or

   c) Pharmacy statement including:
   - Patient name
   - Prescribing physician
   - RX number
   - Name of the drug
   - Date the RX was filled
   - Co-payment amount

   ***Unacceptable Documentation includes the following:**
   - Cancelled checks
   - Credit / cash receipts (An itemized cash register receipt is acceptable for eligible over-the-counter expenses)
   - Balance forward statements

4. Sign and date **Employee Certification.**

5. **Submit Claims to CONEXIS Flexible Benefits Services**:

   By Fax: (877) 864-9555

   By Mail: P.O. Box 226190
   Dallas, TX 75222

CONEXIS
human resourceful®

Request for Reimbursement
Health Care Flexible Spending Account

Employee Information

Employer Name _____

Employee Name _____ Account Number / SSN _____

Street Address _____ Daytime Phone Number _____

City _____ State _____ Zip Code _____

Do you want to know if CONEXIS received and processed your claim? Please provide your e-mail address:

E-mail Address _____

Claim Information

Patient Name	Date of Service	Type of Service	Requested Amount
			$
			$
			$
			$
			$
		Total Amount Requested (continue on additional page if necessary)*	$

Supporting Documentation

Attach Supporting Documentation (*see list of acceptable documentation above)

☐ I have attached copies of Explanation of Benefits (EOBs) for deductible and coinsurance requests.

☐ I have attached itemized bills for expenses not covered by medical, dental or vision insurance.

Employee Certification

- I certify the expenses listed for reimbursement are eligible healthcare expenses under the Internal Revenue Code and my employer's Flexible Benefits Plan ("Plan");
- I certify the services listed above have been received by me, my spouse, or my dependent on the dates indicated;
- I certify these expenses have not been submitted previously for reimbursement under the Plan and such items have not and will not be covered by any other plan or program of any employer or other person;
- I certify the services listed above were not purchased with my CONEXIS Flexible Spending Benefit Card;
- I understand my employer does not accept responsibility for direct payment to any individuals other than the employee;
- I understand the expenses reimbursed may not be used to claim any federal income tax deduction or credit;
- I understand any unused contributions will be forfeited to my employer at the end of the plan year;
- I understand that I may be required to provide further details about some expenses, including a statement from a medical practitioner that the expense is for a specific medical condition;
- If my employer has adopted a grace period, I understand eligible expenses incurred and approved during the grace period will be paid first from available amounts that were remaining at the end of the plan year to which the grace period relates and then from any amounts that are available to reimburse expenses incurred during the current plan year. I further understand claims will be paid in the order in which they are received and previous claims will not be reprocessed or re-characterized so as to change the order in which they were received;
- In the event of an erroneous or excess reimbursement, I understand I am required to reimburse the Plan for the improperly paid amount. I further understand failure to repay the Plan could result in adverse income tax consequences;
- By providing my e-mail address, I authorize CONEXIS to send account information to me via e-mail.

_____ _____

Employee Signature Date

Medical expenses which have been reimbursed under this plan are not deductible for income tax purposes.

* Only the total amount supported by the attached documentation (receipts) will be paid.

Fax: (877) 864-9555 Phone: (877) 864-9549