Flexible Spending Account (FSA) / Limited Purpose Flexible Spending Account (LPFSA) Claim Form

Mail or Fax completed form and documentation to:
PayFlex Systems USA, Inc.
P.O. Box 4000
Richmond, KY 40476-4000
Fax: (888) 238-3539

For the hearing impaired, call 1-877-703-5572

To avoid claim payment delay, you must sign, date and complete this form. You must also include supporting documentation.

WAIT! Did you know that you can file a claim online? Log in to www.PayFlexDirect.com or accessible via Aetna Navigator, select *File a Claim* under Quick Links. You can also find instructions online for completing this form.

Member Identification Number: (*Employer assigned number or W ID*)	**Member Full Name:** (*Last Name, First, MI*)
Member Address: (*Street, City, State, Zip Code*)	

Note: If you have an address change, please notify your employer. For security purposes, we can only accept an address change from your employer.

Employer Name:

Health Care Expenses (For you, your spouse and your dependents)

Coordination of Benefits: Do you, your spouse or dependent have coverage under another plan? This includes any medical, dental, prescription or vision plan other than your primary coverage? ☐**Yes** – you **must** include a copy of the EOB for each date of service ☐**No**

☐ **Automatic Monthly Reimbursement for Orthodontia expenses:** To set up automatic reimbursements, check this box. Include a copy of your orthodontia contract with this form. **Note**: For automatic monthly reimbursements, you only need to send this form and the contract once.

Patient Name	**Type of Service** (deductible, dental, medical, orthodontia, OTC, RX, vision)	**From Date of Service** (not payment date) MM/DD/YYYY	**To/Thru Date of Service** (not payment date) MM/DD/YYYY	**Amount Requested**	Limited Purpose FSA Post deductible **Have you met your health plan deductible?** If yes, EOB must be provided.
				$	☐Yes ☐No
				$	☐Yes ☐No
				$	☐Yes ☐No
				$	☐Yes ☐No
If more lines are needed, please complete another form. You can get claim forms at www.PayFlexDirect.com or accessible via Aetna Navigator under MyPayFlexDirect Resources and select Administrative Forms. Attach the appropriate documentation for each claim.			**Total**	**$**	

Dependent Care Expenses (Child or Adult) - If your caregiver completes and signs below, you do not need to include an itemized statement.

If requesting for multiple dependents, each dependent must be listed on a separate line.

Exact Dates of Service		**Amount Requested** (Required)	**Qualifying Person's First and Last Name** (Please Print)	Age On Service Date (Required)	Qualifying person is under age 13 OR is mentally or physically incapable of self-care due to a diagnosed medical condition and is over age 12. **Please check, if yes.**
From MM/DD/YYYY	**To** MM/DD/YYYY				
		$			☐Yes
		$			☐Yes
		$			☐Yes
		$			☐Yes
Total		**$**	**You do not need to submit evidence of diagnosed medical condition.**		

Caregiver Information/Certification: My signature certifies that I have provided the services for these expenses for _____(Qualifying Person's First Name)

Name *(Must be printed)*_____
Relative: ☐Yes ☐No

Provider Signature _____

Caregiver Information/Certification: My signature certifies that I have provided the services for these expenses for _____(Qualifying Person's First Name).
Note: This is for a second caregiver, if you have more than one.

Name *(Must be printed)*_____
Relative: ☐Yes ☐No

Provider Signature _____

For Health Care FSA: I certify that I, my spouse or eligible dependent have incurred each expense on this form. These expenses are for eligible medical care. They are not for cosmetic reasons. I understand that "incurred" means the service has been provided.

For Dependent Day Care FSA: I certify that I have incurred the Dependent Day Care expenses for me and, if married, my spouse to work. These expenses are for my Qualifying Person. These qualify as eligible expenses under my plan and are not for educational expenses to attend kindergarten or higher. I understand that "incurred" means the service has been provided. These are regardless of when I am billed or charged for, or pay for the service. I acknowledge that I will have to report the caregiver's name, address and Tax Identification Number on Form 2441.

I have not received reimbursement for any of these expenses. I will not seek reimbursement elsewhere, including from a Health Savings Account (HSA). If I receive reimbursement, I and (if married) my spouse will not claim these same expenses on our income tax return. I have received and read the printed material for the FSA or Limited FSA plan. I agree to all of the terms and conditions of the plan. Any person who, knowingly and with intent to defraud, files a statement of claim containing any material false, incomplete or misleading information is guilty of a crime.

Employee Signature_____ **Date** _____

If you are mailing your claim, please keep a copy of this claim form and supporting documentation. We will not return these documents. *REV. 08/2012*