PRIMEPAY®

Claim Reimbursement Form

Please complete all fields and include documentation for each expense item.
Send this form and supporting documentation for each expense item listed below to Benefit Services by fax or email:
Fax: (877) 632 - 9472
Email: primeflex@primepay.com

Reset Form

Employee Information (Please print clearly) ☐ **PLEASE CHECK HERE IF THIS IS AN ADDRESS CHANGE**

Name: (Last, First, Middle)		SSN:		Date of Birth:
Street:	City:		State:	Zip:
Employer:				Work #:
Email:				Home #:

Account Type (Ex. HRA, FSA)	Description of Expense	Family Member	Dates of Service	Amount of Claim
Select One				
Select One				
Select One				
Select One				
Select One				
*Please consult your plan documents for a list of eligible expenses.			Total	

☐ **Yes, please issue payment directly to the medical provider(s) of service. I confirm that I have completed the provider pay information below *and* have included the MEDICAL INVOICE for each provider. All INFORMATION IS REQUIRED.**

Medical Provider Name: (Make check payable to)			
Provider Address: Street	City	State	Zip
Patient Account Number:			

For Dependent Care Claims, please fill in the fields below and: (1) submit an itemized receipt detailing the services, or (2) have the provider sign the line below.

DCA Provider Name	Tax ID/SSN	Dependent	Dates of Service		Amount
			From:	To:	
			From:	To:	

I, as the Dependent Care Provider listed, certify that the above services were provided for the amount listed and during the dates listed.

Dependent Care Provider Signature: _____ **Date:** ____/____/____

IRS tax code requires all health FSA and HRA claims be substantiated to ensure only legitimate claims are paid, and if the substantiation requirement is not met, the IRS could disqualify the plan and treat all reimbursements as taxable.
HRA expenses typically require an Explanation of Benefits (EOB) for substantiation.
Learn more about claim substantiation at support.primepay.com or contact us at (**877) 769 - 3539** or **primeflex@primepay.com**.

Our Mobile App and Wealthcare Portal make manual claims submission easy!
To learn more, check out our participant video library at support.primepay.com or contact us at **(877) 769 - 3539** or **primeflex@primepay.com**.
If you are ready to get started, go to **primepay.wealthcareportal.com** or download the **PrimeFlex Mobile App** from your App Store today!

I confirm that I am a participant in the plan(s) for which reimbursement is being requested. I confirm that all claims being reimbursed are for myself and/or a qualified beneficiary in accordance with my enrollment form into the plan. I confirm that all amounts claimed are not eligible for reimbursement/payment under any other plan or program and no medical expense tax deduction may be made on claimed amounts. I confirm that all claims are qualified expenses and that I am fully responsible for the sufficiency, accuracy, and validity of all information relating to above claim(s). I understand that I must retain all receipts for purchases and services rendered, and agree to provide them upon request. I understand that voided checks and credit card statements are not valid proofs of payment. I understand that failure to comply with all of the above requirements may result in a pended or denied claim. I confirm that all of the information is correct.

Employee Signature: _____ **Date:** ____/____/____