FLEXFACTS
a company of grant benefit solutions

Please send the completed claim form and claim documents to:

Email: claims@flexfacts.com **Fax:** 877-747-8564

Mail: 1200 River Avenue, Suite 10E, Lakewood, NJ 08701

Medical FSA Claim Form

STEP 1 Employee Information

Full Name: _____ _____ _____
Last Name First Name Middle Initial

Employer: _____ Last 4 digits of Social Security #: _____

Phone: _____ Email: _____

Address: _____ _____ _____ _____
Address City State Zip

☐ Check here if submitting a Change of Address

STEP 2 Medical Claim

Date of Service	Patient Name	Name of Provider	Description of Service	Amount Requested	Pay Me	Pay Provider*
					☐	☐
					☐	☐
					☐	☐

*if pay provider is selected, please be sure to include bill with provider's mailing address

STEP 3 Direct Deposit (skip this step if you are already enrolled in direct deposit)

Bank Name	Account #	Routing #	Account Type (Checking/ Savings)

By signing this form, I authorize Flex Facts to initiate debits and/or credits to or from my bank account indicated above. Debits will only be initiated in order to correct a reimbursement error. My authorization will remain in effect until I provide written notification of termination of this authorization or change my direct deposit information online. A reasonable amount of time will be provided for Flex Facts to apply any requested changes.

STEP 4 Employee Certification

By signing this form, I agree to have my benefit account(s) reduced by the amount(s) requested. I certify that the expenses above were incurred by me (and/ or my spouse and/or eligible dependents) during the applicable plan year and are eligible for reimbursement under my Plans. (Please refer to your SPD/ Plan Document for information on eligible expenses). I certify that these expenses have not previously been reimbursed by this or any other benefit plan, will not be reimbursed from any other source and will not be claimed as an income tax deduction. I understand that I may be asked to provide further details or documentation.

Employee Signature: X_____ Date: _____

STEP 5 Submit this signed form and copy of required claim document(s). FSA Claim Documents must include:

- Provider Name
- Patient Name
- Date of Service
- Description of Service
- Amount