ProBenefits

Claim Form

Total # Pages Sent: _____

Fax-a-Claim: (866) 329-3539 [866-Fax-Flex] or Email to: Flex@ProBenefits.com (PDF only)
Or skip this form and log on to your account at ProBenefits.com to submit online

***Employer:** _____

***Participant Name:** _____

Social Sec #: _____ **Daytime Phone:** _____

Mailing Address, if changed: _____

Email Address: _____

Used to send you a confirmation after your claim is processed

Paid with Flex Card?	Provider Name	Description of Expense (Ex: Rx, Office Visit, Deductible, Daycare)	Type of Expense			*Dates of Service		*Amount of Expense
			Med HRA	Med FSA	Dep Care	Begin	End	
☐			☐	☐	☐	___/___/___	___/___/___	$
☐			☐	☐	☐	___/___/___	___/___/___	$
☐			☐	☐	☐	___/___/___	___/___/___	$
☐			☐	☐	☐	___/___/___	___/___/___	$
☐			☐	☐	☐	___/___/___	___/___/___	$

If you have more expenses, please list them on a separate page, and include the full total amount of your claim here. ***Total:** $

Comments: _____

Important Notes:

- **Please submit documentation for all expenses claimed on this form.** Per IRS Regulations, all claims must be adjudicated based on provider receipt(s) indicating the following: Dates of Service & Amount of Expense; Type of Service (e.g., Office Visit, Rx, Childcare); and Name of Provider (e.g., Doctor, Hospital, Childcare Giver). **For an HRA claim, in most cases an EOB is required.**
- **Non-itemized credit/debit card slips or cancelled checks *will not* be accepted as valid documentation for any claim.**
- For Dependent Care, per IRS regulations:
  - Eligible expenses are for custodial care for children age 12 and under or for dependent, disabled adults.
  - IRS requires that the name, address, and tax ID number of your childcare provider be given. If not included on your receipt, please include in Comments above.
- The method of reimbursement for your claim will be determined by the information on file in your account. To view or change your reimbursement information, please log in at www.ProBenefits.com.
- If you email your claim, please use only PDF format for your file attachment. Other formats cannot be accepted.
- **If your claim is an HRA, any portion not reimbursed by your HRA account will be applied to your ProBenefits Health FSA, if you have one (if applicable to your plan).**

Certification: These expenses were incurred (have a date of service) by me and/or my spouse or eligible dependents during the plan year while I have been a covered participant and to the best of my knowledge are reimbursable by the plan. I, the participant, certify that I have not been reimbursed for the above expense(s) and that I will not seek reimbursement under any other plan covering health benefits, such as my spouse's health plan. I understand that any expense reimbursed under this Plan may not be used to claim any income tax deduction or credit. I also understand that privacy regulations prohibit ProBenefits from discussing claims with anyone other than the participant.

***Signature** _____ ***Date** _____

**All items marked are required for processing.*

2640 Reynolda Road · Winston-Salem, NC 27106-3817 · (336) 761-1850 · (888) 722-8382 · Fax (877) 761-1850 · Flex@ProBenefits.com · www.ProBenefits.com

Log in to ProBenefits.com to check claim status, view account details, submit claims and more.

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