Courtesy Flip Request Form

Ameriflex

Employer name:
Employee name:
Member ID (which may be your SSN):
Phone:
Email:

Documentation is attached to flip the following transaction(s) from the _____ plan year, to the _____plan year.

Transaction Date:
Provider Name:
Amount of Transaction:

Transaction Date:
Provider Name:
Amount of Transaction:

Transaction Date:
Provider Name:
Amount of Transaction:

Please note that depending on your account type, either an Itemized Receipt or Explanation of Benefits will be required and the documentation must include the date of service, service(s) rendered, amount charged and the name of provider.

Please complete all fields. Incomplete forms will delay processing. Send completed form to:

Email
Send completed form to:
service@myameriflex.com

Mail
Ameriflex Claims Department
P.O. Box 269009
Plano, Texas 75026

Please do not send original documents. If damaged or lost during processing, they cannot be replaced.

I understand I can only request one Courtesy Flip per plan year.

To the best of my knowledge and belief, the above statements are complete and true. I certify all of the following: Either I or my eligible dependent has received the services described above on the dates indicated; the expense(s) qualify as valid medical expenses under my plan; if the expense is for my spouse/dependent, that person is my spouse or dependent as defined by my have not been and will not be reimbursed by any other source for this expense.

Signature *Date*