INSTRUCTIONS: Please read carefully and be sure your claim is completed in its entirety to ensure there is no delay in processing. Please do not use a highlighter on claim form, receipts, or any documents included as backup as this may cause a delay in processing your claim.

- Complete all applicable sections, sign and date. Services must be incurred in order to be reimbursed
- Attach all required documentation
- Mail, fax or email the completed claim form (scanned with signature if necessary) to Ameriflex
- Please allow 2-3 business days for claims processing from the date the claim is received
  Direct Deposit: 3-5 business days from the date the claim is processed
  Check Delivery: 7-10 business days from the date the claim is processed

ICHRA Expenses | Acceptable forms of documentation include:

- Explanation of Benefits (EOB): Your insurance carrier sends you an EOB each time a claim is filed. An EOB indicates your personal obligation via co-insurance or a deductible.
- Receipts: include name of person treated; date expense was incurred; type of service; provider name; and amount of expense. IRS does not allow credit card receipts)
- Proof of insurance premiums (if applicable): If requesting reimbursement for insurance premiums, include a carrier invoice or a receipt of premium payment including name of person covered by the insurance, name of insurance, date of coverage and dollar amount of premium.

To avoid delays in reimbursement, please sign and date this claim form and provide notice of any name or address change to Ameriflex.

ICHRA Spending Account Claim Form

Ameriflex

STEP 1

Employer Name: _____

Employee Name: _____

Phone: _____ **Email:** _____

Member ID (which may be your SSN):

STEP 2 **Medical Expense Claims**

Date Expense Incurred	Name of Person Receiving Medical Service	Provider Name (Carrier, Physician, Pharmacy, etc.)	Service Provided (Premium, Co-Pay, Deductible, RX, etc.)	Amount Requested

STEP 3 **Complete the following for any expenses being reimbursed from the ICHRA. Form cannot be processed without valid attestation and signature.**

I, _____, am requesting reimbursement for a medical care expense incurred during _____, and for that month I am (or was) covered under the following health coverage:_____.

Instructions: Complete the following if you're requesting reimbursement of a family member's medical care expense from the individual coverage HRA. I, _____, am requesting reimbursement for a medical care expense incurred by _____, during _____, and for that month this family member is (or was) covered under the following health coverage:

_____.

By signing this form, I hereby affirm that the above information is true and accurate. I also hereby authorize my account to be reduced by the amount requested. To the best of my knowledge and belief, the statements on this form are complete and true. I am claiming reimbursement only for eligible expenses incurred by eligible plan participants during the applicable plan year. 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 also understand that I may be asked to provide further details (i.e. a letter of medical necessity from a medical practitioner certifying that the expense is to treat or cure a medical condition or a more detailed certification from me).

Employee Signature **Date**

Please email, fax, or mail to:

Email
claims@myameriflex.com

Fax
888.631.1038
Attention: Claims Department

Mail
Ameriflex Claims Department P.O. Box 269009 Plano, TX 75026
Please do not send original documents. If damaged or lost during processing, they cannot be replaced.