

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

Documentation is attached to offset the following transaction(s):

Account Type:
Transaction Date:
Provider Name:
Amount of Transaction:

Account Type:
Transaction Date:
Provider Name:
Amount of Transaction:

Account Type:
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 to offset the transaction. The documentation must include the date of service, service(s) rendered, amount charged and the name of provider.

Email

Send completed form to:
claims@myameriflex.com

Fax

888-631-1038
Attention: Claims Department

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.

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 plan; I have not been and will not be reimbursed by any other source for this expense.

Signature

Date