

How to File

Submit This Form OR the Benefits Card Letter

Please send (a) this form along with (b) required documentation.

Form can be submitted by (1) e-mail, (2) fax or (3) mail.

To submit by e-mail, Print Form and sign. E-mail form along with receipts to benefitscard@flex-admin.com*

To submit by fax, Print Form and fax to: 757-431-1155

To submit by mail, Print Form and mail to: Flexible Benefit Administrators, Inc.

P.O.Box. 8188, Virginia Beach, VA 23450

Reminder:

- Do not mail your completed form if you fax it.
- Keep a copy of all completed forms and receipts for your records.
- Notify Flexible Benefit Administrators, Inc. if you have a change in address.

* E-mail will result in the quickest verification to your substantiation.

Employee Information

Employee's:
Print name

E-Mail address (For Notification of Processed Claims, Reimbursement & Account Status)

Social Security # or Employee ID:

Employer

Expenses

1	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>
	Date of Transaction	Name of Merchant	Type of Eligible Expense	Amount of Transaction
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>
	Date of Transaction	Name of Merchant	Type of Eligible Expense	Amount of Transaction
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>
	Date of Transaction	Name of Merchant	Type of Eligible Expense	Amount of Transaction
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>
	Date of Transaction	Name of Merchant	Type of Eligible Expense	Amount of Transaction

Total:

Good Receipt

Receipt Missing Information

Rx Pharmacy 08-14-2012

(212) 555-1212 CUSTOMER RECEIPT

33945 0034233 3322

Customer: **JOHN SMITH**

VIGAMOX 0.5% EYE DROPS
Instill one drop 4 times per day

Pay: \$ 50.94

Rx Pharmacy, Inc. 700 Viking St., Somewhere, VA 11111

ABC EYE ASSOCIATES
700 Viking St.
Somewhere, VA 11111

DATE: 08-14-2012 TIME: 08:15AM

ITEM: 0034 MC SALE
ACCT: XXXXXXXXXXXX30
AUTH: 9999

TOTAL: \$ 50.94

I AGREE TO PAY ABOVE AMOUNT
ACCORDING TO CARD ISSUER AGREEMENT
(MERCHANT AGREEMENT IF CREDIT VOUCHER)

X _____

no description of items purchased

I, the participant, hereby certify that each expense was incurred on the date and for the reason noted. The expense(s) listed was incurred for medical care, not general health purposes, and excludes cosmetic and/or toiletry expenses. I, the participant, certify that I have not been reimbursed for the expense(s) noted above and that I will not seek reimbursement under any other plan covering health benefits. I, the participant, further certify that the expense(s) noted above has been paid for by use of my Benefits Card.

Attached are itemized receipts or bills to substantiate my Benefits Card transaction. I understand that I may NOT use this form to seek reimbursement for items paid out-of-pocket; I may do so by filing a Claim Form, found at www.flex-admin.com.

Please Note: A letter of medical necessity must be attached if the drug is considered a "dual purpose" item.

I authorize the service provider to release any information requested by the Plan Administrator in connection with this transaction.

Employee's Signature: Date: