



Fax to:
 ASIFlex
 (877) 879-9038
 No Cover Page Required
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HRA CLAIM FORM

 Last Name, First Name, MI (Please Print)

 Social Security Number

 Street Address

 City, State, Zip

Health Reimbursement Account Expenses

Date Medical Care Provided*	Name of Medical Provider	General Medical Expense Description	Patient Name	Eligible Amount (documentation required)	ASIFlex Use Only
Total Health Care Amount Requested —————▶					

***Claims for future services will not be accepted.**

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under his/her employer's Health Reimbursement Arrangement with respect to such expenses and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

 Employee's Signature

 Date

ASIFlex
 P. O. BOX 6044
 COLUMBIA MO 65205-6044
 TOLL-FREE FAX (877) 879-9038 ****No Cover Page Necessary****

Mail or FAX to ASIFlex **ALONG WITH SUPPORTING DOCUMENTATION**
 E-mail: asi@asiflex.com
 Website: www.asiflex.com

Claim Filing Requirements

1. **Print your name, address, social security number or employee ID (EID) as appropriate and your employer's name.**
2. **List expenses by date & arrange the supporting statements in the same order.** Highlight or circle the service dates on your documentation.
3. **Enclose the Explanation of Benefits statement you received from your insurance provider**
 - Submit an EOB or other detailed billing statement to receive reimbursement.
4. **Sign** the claim form.
5. **Keep** copies for your tax records.
6. **Mail** to the address on the front of this form or **Fax to (877) 879-9038**. This is a toll-free number but employee use of an office fax machine may not be appropriate. Please check with your employer before using an office fax machine.

Please contact ASIFlex with questions at (800) 659-3035, or via email at asi@asiflex.com.