FLEXFACTS
a company of grant benefit solutions

Please send the completed claim form and detailed bills/ EOBs to:

Email: claims@flexfacts.com **Fax:** 877-747-8564

Mail: 1200 River Avenue, Suite 10E, Lakewood, NJ 08701

Medical & Dependent Care Claim Form

STEP 1 Employee Information

Full Name: _____ _____ _____
Last Name First Name Middle Initial

Employer: _____ Last 4 digits of Social Security #: _____

Phone: _____ Email: _____

Address: _____ _____ _____ _____
Address City State Zip

☐ Check here if submitting a Change of Address

STEP 2 Medical Claim

FSA	HRA	Date of Service	Patient Name	Name of Provider	Description of Service	Amount Requested	Pay Me	Pay Provider*
☐	☐						☐	☐
☐	☐						☐	☐
☐	☐						☐	☐

*if pay provider is selected, please be sure to include bill with provider's mailing address

STEP 3 Dependent Care Claim

Service Period (From)	(To)	Dependent Name	Dependent Date of Birth	Name of Provider	Description of Service (Day Care, Pre-K, Day Camp, etc.)	Provider Tax ID/ SSN	Amount Requested

Dependent Care Provider Signature (if bill is not available): _____

STEP 4 Direct Deposit (Skip this step if you are already enrolled in direct deposit)

Bank Name	Account #	Routing #	Account Type (Checking/ Savings)

By signing this form, I authorize Flex Facts to initiate debits and/or credits to or from my bank account indicated above. Debits will only be initiated in order to correct a reimbursement error. My authorization will remain in effect until I provide written notification of termination of this authorization or change my direct deposit information online. A reasonable amount of time will be provided for Flex Facts to apply any requested changes.

STEP 5 Employee Certification

By signing this form, I agree to have my benefit account(s) reduced by the amount(s) requested. I certify that the expenses above were incurred by me (and/ or my spouse and/or eligible dependents) during the applicable plan year and are eligible for reimbursement under my Plans. (Please refer to your SPD/ Plan Document for information on eligible expenses). 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 understand that I may be asked to provide further details or documentation. I understand and agree that I am obligated to inform Flex Facts in writing if the amount charged for the dependent care services change, the service is terminated, or if there is any reason the expenses are not incurred.

Employee Signature: X_____ Date: _____

STEP 6 Submit this signed form and copy of required bill(s)/ EOB(s).

- ✓ **HRA:** Explanation of Benefits (EOB)
- ✓ **FSA/ Non-HRA Medical:** Medical bill (must include Provider Name, Patient Name, Date of Service, Description of Service, Amount)
- ✓ **DCA:** Dependent care bill (must include Provider Name, Amount)