Medical Expense Claim Form

FAX: 469-398-0423

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To make a claim for reimbursement of your medical, dental and vision expenses, please complete this form and attach copies of the Explanation of Benefits from your insurer or copies of the imprinted, personalized and detailed bills prepared by your care providers. Charge card or cash register receipts must show detailed information on the services received or items purchased. Detailed pharmacy bills including the name of the medication are required for non-standard co-payment amounts.

Mail your claim and documentation to:

FlexToday, Inc.
PO Box 16099
Fresno, CA 93755

REQUIRED: Your Full Name (First and Last)
REQUIRED: Address
REQUIRED: City, State and Zip Code

PLEASE READ AND SIGN HERE - I hereby understand, certify and agree that: The expenses submitted for reimbursement have not been reimbursed or paid previously and I will not seek payment or reimbursement under insurance or other benefit plan for these expenses; These expenses were incurred during the coverage period by either me or my eligible dependents; I assume the responsibility to maintain substantiating documents for all claims; I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim; I am liable for payment of any taxes and penalties, federal, state or local, related to expenses claimed or paid that are not eligible expenses under the Plan(s); These expenses cannot be claimed as credits or deductions on my personal tax return if reimbursed or paid from the Plan(s); Any medically related expenses submitted are to diagnose, alleviate or prevent a medical condition and not merely beneficial to general health; If my spouse or I make or receive contributions to a Health Savings Account (HSA), my benefits are considered Limited Purpose and I will only submit claims for qualifying expenses related to preventive care, vision care, dental care and/or post-deductible expenses; I have received a copy of the Summary Plan Description(s) and understand that this claim is subject to the terms and requirements of the Plan(s), including but not limited to eligibility, coverage period and claims filing deadlines; I may receive notifications by email instead of mail and understand that I must notify FlexToday in writing to rescind this authorization to send notifications by email; and, My digital signature on this form will be accepted as binding with the same weight and consideration as a pen and paper signature.

REQUIRED: Sign Here Date Signed

REQUIRED FOR DIGITAL SIGNATURE ACCEPTANCE:

Email Address:	
Last 4 numbers of SSN	Full Date of Birth

Total Medical Expenses Claimed With This Request: $__________________

Name of Person Receiving Care	Relationship to Employee	Date service provided	Name of the Care Provider	Type of Service	This is my cost for this service
					$
					$
					$
					$
					$
					$
					$
					$
					$

FlexToday, Inc. • 191 W Shaw Ave Ste 101 • Fresno, CA 93704 • Ph: 559-432-6800 or 800-995-5373
Claims Fax **469-398-0423** • Alternate Fax Numbers 214-716-1134 or 480-772-4122 • Secure Claims Portal Link

We accept claims by fax, mail or electronically at the Secure Claims Portal (the Portal). **We do not accept claims by email.** Claims sent to the Portal should be in Adobe Acrobat format with both the claim form and supporting documents in a single file. PLEASE identify yourself in the "Add A Message" box. Unidentified files and files sent in any format other than Adobe Acrobat may not be considered a claim submission. Files sent to the Portal in executable formats will be deleted without opening, including but not limited to file formats such as: .exe, .zip, .eml, .com, .html and .vbs.