



# AMERIFLEX

## Health Care Reimbursement Account Claim Form

[Click here for Health Care Reimbursement Account Plan Rules](#)

Submit one claim form for each patient for who expenses are claimed. Attach all applicable insurance claim settlement statements and copies of paid receipts specifying service provided and patient name. Do not submit balance forward statements.

Employee Name	SSN Number	
Patient Name	Age	Relationship

### SECTION A

Date of Service	Description of Service	Select One		Expense Amount
		Health	Dental	

Section A Total =

### SECTION B

Number of Trips	Number of Miles Roundtrip	Doctor/Service Facility	Mileage Reimbursement	
			x .10 =	
			x .10 =	
			x .10 =	
			x .10 =	

Section B Total =

### SECTION C

When lodging away from home is required, you may claim a maximum of \$50.00 per night for each eligible individual. You may not claim meals.

Section C Total =

Sum of A, B and C Total account claimed for reimbursement =



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## INSURANCE INFORMATION

The patient listed above covered under  
a **Health Plan**. If covered,

Name of Health Insurance Company

Plan/Policy Number

Address

Telephone Number

The patient listed above covered under  
a **Dental Plan**. If covered,

Name of Dental Insurance Company

Plan/Policy Number

Address

Telephone Number

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## MEDICAL AUTHORIZATION

I authorize any insurance company, organization, employer, hospital, physician, or pharmacies to release any information requested with regard to this claim and the expenses reported. I certify that the information I furnish in support of this claim is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important. I have also read the [Health Care Reimbursement Account Plan Rules](#) and I certify that the Health related expenses listed qualify under the plan rules. I further certify that the expenses listed are not reimbursable under any insurance plan. I do understand that expenses claimed for reimbursement may not be claimed as itemized deductions on my tax return.

Employee Signature

Date

Dependent Signature (if not a minor)

Date

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Original to AmeriFlex ([see instructions](#))  
Please retain a copy for your records.

*Revised 03/07*