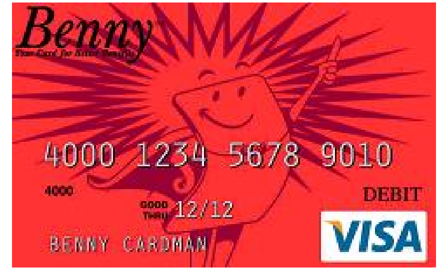
Debit Card Claim Submission
Health Care Reimbursement Plan



When completed, mail or fax with documentation to:

Flex Corp
820 Gessner, Suite 1225
Houston, Texas 77024
Phone: (866) 401-5272
Fax: (866) 254-2942

IMPORTANT NOTES

SKIP THE FORM AND SUBMIT YOUR CLAIMS ONLINE! Go to www.bpas.com, roll over the Participant Accounts tab and select Flex Account from the drop down menu. Click on the link: Account Access and log into your personal account. After you have logged into your account, roll over the My Account tab and click New Claim!

For medical, dental and optical expenses, documentation will include an explanation of benefits (from insurance carrier) or legible copy of the itemized statement which includes the following: Name and address of the provider of service, name of patient or whom the service was rendered to, the date the service was provided, a description of the services rendered and the charges for the services. Prescription drugs documentation will include a legible copy of the original drug ticket (not the cash register tape) which includes the date the prescription was filled, the name of the patient, the name of the doctor prescribing the drug, the name of the drug and the name and address of the pharmacy from which the drug was purchased.

*** OVER-THE-COUNTER ITEMS ***

Effective 1/1/11: Employees with an FSA or HRA can no longer use their account funds to purchase OTC drugs and medicines (e.g. Advil, ibuprofen, cough syrup) unless they have a legible prescription from a physician. If an employee has a prescription for an OTC medicine or drug, the employee must pay out of pocket at the point of sale, then submit a manual claim that includes a legible copy of a customer receipt issued by a pharmacy that reflects the date of sale and the amount of the charge along with a copy of the legible prescription when requesting reimbursement. Employees can continue to use their FSA funds to purchase OTC items that are not considered a drug or a medicine (e.g. bandages, wound care, contact lens solution).

Employer Name: ______________________________

Employee Name: ______________________________

Social Security #: ____________________ or Alternate ID #: ____________________

I have recently used my health care reimbursement plan debit card to pay for medical care expenses. I am submitting this form with the documentation to substantiate that such use of the card was for eligible expenses under the plan, and were for expenses that were incurred by myself, spouse or an eligible dependent (NOTE: For this purpose, a dependent must be someone who qualifies as your tax dependent for federal income tax purposes). I understand that if any part or all of such use of the card was for ineligible expenses, I will be notified and required to repay to the plan any amounts not eligible. I certify that these expenses have not been paid, nor will I seek reimbursement, from any insurance company under which the service recipient is currently insured.

____________________________ ____________________
Employee Signature Date