FLEXMAGIC® CONSULTING, INC.
Employee Benefit Consulting Services

Return this Claim Form and documentation to: TPA Claims Dept., ***FlexMagic®*** Consulting, Inc., 6450 S. Quebec St. Suite 5-28, Centennial, CO 80111
Fax to: 303-649-1925 or 800-889-6260 E-mail to: claims@flexmagic.com
Questions: 800-888-9084 or 303-649-1922

Health Reimbursement Arrangement (HRA) CLAIM FORM

Employee Information (*Please Print*)
Employee Name: _____ Employee ID # _____
Company Name: _____ Day Phone # _____
Plan Year: _____

Description of Expenses and Claim Amounts Requested

Enter each expense on a separate line and attach any necessary copies of receipts to this form.

HEALTH CARE EXPENSES (See Plan Information and Rules Page for eligible and excluded expenses)					
Dependent Name	Relationship	Types of Service	Dates of Service From	To	Claim Amount
Total Health Care Claim Submitted					$ _____

EMPLOYEE'S CERTIFICATION OF CLAIM REQUEST

I certify that I incurred the expenses requested for reimbursement from my Employer-Sponsored HRA Plan. The expense(s) have been incurred and **will not be reimbursed by any other insurance or company plan**. To the best of my knowledge and belief, they are eligible for reimbursement under my HRA. I will not use the expenses reimbursed through the Plan as a deduction when filing my income tax return.

Any person who knowingly and with intent to injure, defraud or deceive any qualified plan, files a statement of claim containing false or incomplete information may be guilty of a criminal act punishable under the law.

Health Insurance Portability and Accountability Act (HIPAA)

Under HIPAA regulations you are assured that certain health information, referred to as Protected Health Information (PHI), will be kept confidential. Disclosure of your PHI for any purpose other than for "Plan Administration" such as quality assurance, claims processing, auditing and monitoring or for the purpose of obtaining payment will be limited and subject to state and federal regulations. To learn more about these Privacy Rules contact your HRA Coordinator to receive a complete Notice of Privacy Practices.

Employee Signature_____ Date_____

INTERNAL USE ONLY Claim Review By: _____ Claim Entry Date: _____