Submitting your Health Care Claim

Review these instructions before submitting your claim…

Go Green! Submit Claims online…
Visit:
http://Texflex.adp.com

FAX
1-866-643-2219

MAIL
ADP Spending Accounts, P.O. Box 34700, Louisville. KY 40232

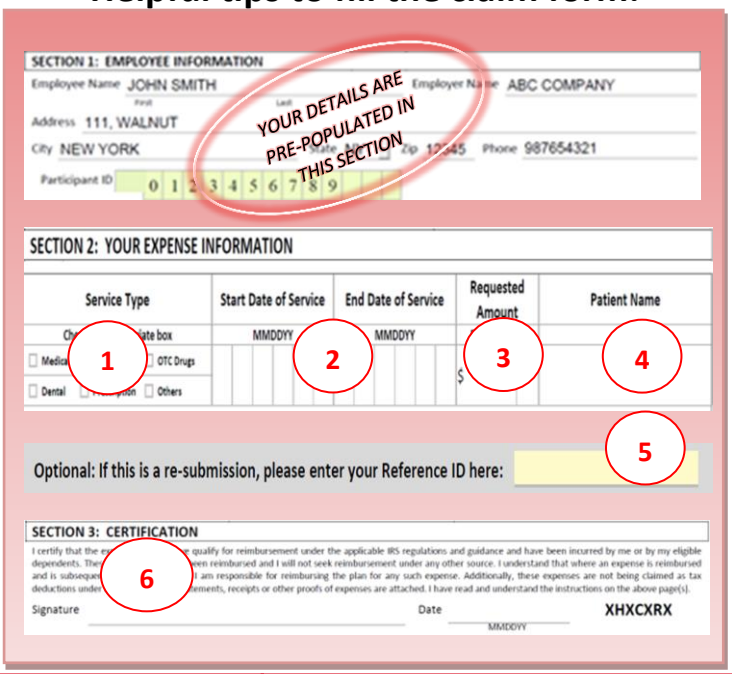
SECTION 1: EMPLOYEE INFORMATION

Your details (Employee Name, Employer Name, Address, Phone number and Participant ID) are pre-populated in this section for your convenience.

For any updates to your pre-populated information shown here, please contact your Employer or HR representative.

1 – Select an appropriate Type of Service incurred

Helpful tips to fill the claim form:



2 – The Date the Service was incurred (should match the receipts or EOB)

3 – The Amount of the expense

4 – Patient / Service recipient's name

5 – This can be a document ID or any other Reference ID given by ADP (optional)

6 – Claim Form received without signed certification cannot be processed

What do we need on the receipts?

- Date the service was provided or item was purchased
- Amount paid for the service or item
- Description of the service or item
- Name of the service provider or merchant

Important: All over the counter medicine/drugs require a copy of doctor's prescription or a receipt containing an Rx number

DO'S

- Preferably TYPE your claim information in this form and PRINT
- Only use blue or black ink if filling out this form by hand
- For faster reimbursements, enroll in FREE Direct Deposit online
- Submit your claims on or before the run out date
- You may refer to the online eligible expense guide before submitting claims
- This claim form should be used only for the Health Care out of pocket expenses
- Include all supporting documents/EOB/receipts for all the expenses associated with this claim

DON'TS

- Avoid faxing & mailing the same claim
- Avoid using a photocopy of this claim form
- Refrain from highlighting receipts or any part of the form
- Do not staple copies of your receipts to the claim form
- Don't include this instruction sheet along with your fax/mail
- Refrain from combining multiple expenses - list each expense on a separate claim line (use more forms if needed)

Please note that your employer's pursing rules determine which account your claim is paid from

For Questions Call Customer Service : 1-844-884-2364

TEXFLEX

Health Care Claim Form

FAX TO: 1-866-643-2219 TOLL FREE

Use this form only if you paid for an eligible expense out-of-pocket and are requesting funds be reimbursed to you.

HQCQFQ

Reset

Go Paperless & avoid filling out this form. Submit claims online for fast and secure processing!

Visit: http://Texflex.adp.com

This information is privileged and confidential. If you are not the intended recipient, notify the sender immediately and destroy this document and all supporting attachment. Further use or disclosure is strictly prohibited.

TIPS TO REMEMBER WHEN SUBMITTING HEALTH CARE EXPENSES:

1. Preferably TYPE your claim information in this Form and PRINT. Don't use red ink, if filling out this form by hand
2. Do NOT mail original receipts. Credit Card receipts & Cancelled checks are NOT acceptable
3. Claim form MUST be signed, dated & submitted with itemized receipt or EOB (Explanation of Benefits)
4. Most Over The Counter (OTC) items now require a copy of doctor's prescription or a receipt with Rx number for reimbursement

SECTION 1: EMPLOYEE INFORMATION

Employee Name _____ Employer Name _____

First Last

Address _____

City _____ State _____ Zip _____ Phone _____

Participant ID : | | | | | | | | | | | | | |

Note: For any updates to your pre-populated contact information above; please contact your Employer or HR representative.

SECTION 2: YOUR EXPENSE INFORMATION

Service Type	Start Date of Service	End Date of Service	Requested Amount	Patient Name
Check the appropriate box	MMDDYY	MMDDYY	Dollars . Cents	
☐ Medical ☐ Vision ☐ OTC Drugs ☐ Dental ☐ Prescription			$	
☐ Medical ☐ Vision ☐ OTC Drugs ☐ Dental ☐ Prescription			$	
☐ Medical ☐ Vision ☐ OTC Drugs ☐ Dental ☐ Prescription			$	
☐ Medical ☐ Vision ☐ OTC Drugs ☐ Dental ☐ Prescription			$	
☐ Medical ☐ Vision ☐ OTC Drugs ☐ Dental ☐ Prescription			$	

Optional: If this is a re-submission, please enter your Reference ID here: _____ $ _____ **Total Expenses**

FAX: 1-866-643-2219 Toll Free

MAIL: ADP Spending Accounts
P.O. Box 34700
Louisville, KY 40232

CUSTOMER SERVICE: 1-844-884-2364

For Admin Use Only

Control Number:

Participant ID:

SECTION 3: CERTIFICATION

I certify that the expenses listed above qualify for reimbursement under the applicable IRS regulations and guidance and have been incurred by me or by my eligible dependents. The claimed expenses have not been reimbursed nor will I seek reimbursement from any other source. I understand that where an expense is reimbursed and is subsequently deemed ineligible, I am responsible for reimbursing the plan for any such expense. Additionally, these expenses are not being claimed as tax deductions under the IRS code. Bills, statements, receipts or other proofs of expenses are attached. I have read and understand the instructions on the above page(s).

Signature _____ Date _____

MM DD YY

HQCQFQ