FLEXIBLE BENEFITS PLAN CLAIM FORM
UNREIMBURSED MEDICAL CARE EXPENSES

To be reimbursed, please complete in full, sign/date and attach supporting documentation for every expense. Receipt must include patient name, type of service provided or drug name, date(s) of service and amount of patient responsibility. Over the counter (OTC) receipts must include the name or description of the eligible expense. IRS has determined a cancelled check, credit card receipt or statement is not sufficient documentation. An Explanation of Benefits (EOB) is considered proper documentation

Please complete form in full, sign/date & include copies of supporting documentation for each expense.

Member Information	SSN	Full Name	Daytime Phone Number
Employer			Other Phone Number
Full Home Address			☐ **Check if New Address**
E-mail Address*			☐ **Check if New E-mail Address**

*** You will receive notification by email when you claim is processed and another when a payment is issued. You will also receive email notification of direct deposits. Be sure your email address is current and legible.**

Date(s) of Service (not payment date) One expense per line	**Provider Name** (CVS, Walmart Dr. James Smith, Laboratory Services)	**Expense Description** (Rx, copayment orthodontics, over-the-counter medication, etc.)	**Relationship** (self, spouse, child)	**Amount Requested**	
	TOTAL UNREIMBURSED MEDICAL EXPENSES INCURRED			**$**	

Employee Certification

I certify I have incurred expenses for which reimbursement is claimed from the Flex Spending Account, and I further certify all medical expenses listed above and on any attached documents have not been reimbursed or will not be submitted for reimbursement from any other source. They are not for cosmetic reasons. I also certify the above medical care expenses were incurred for the medical care of me, my spouse and/or qualified dependent. I acknowledge I am fully responsible for the accuracy of all information relating to this claim. If an expense for which I am reimbursed is later disallowed by the Internal Revenue Service, I understand I will be liable for payment of any related income or payroll taxes relating to such improper expense reimbursement.

Signature_____ **Date**_____

Claim Return Policy

If you submit a claim for an expense that is determined ineligible, for a time when you were not enrolled in the plan or submitted with insufficient documentation, PRN may request additional information to substantiate the claim. We will include an explanation of any corrective measures (if any) you must take before the claim can be processed. Please make necessary corrections and return the form. The claim will be processed on the next regularly scheduled processing date.

Claim Submission

Please submit claim form and copies of supporting documentation to:
Mail: Phillips Resource Network Flex Department, PO Box 653, Overland Park, KS 66201-0653
Fax: 913.261.0083
Email: PRNS125@phillipsresource.com
Online: www.phillipsresource.com

Please keep originals for your files. Documents cannot be returned.

rev 4/2014