CLAIM FORM

Today's Date: _____/_____/_____ # of pages: _____ Plan Year: 20_____

❑ New Claim ❑ Response to Claim Denial

Employer Name/Division Name:	Employee Name:	
Address: ☐ Please check if change of address		
Social Security Number:	E-mail Address:	Home Phone: Work Phone:

❑ **Medical Expense Reimbursement Account** **Total Amount Requested:**_____

- Enclose insurance company statement or itemized bill from provider showing date of service, services rendered, provider of service, amount paid and, if applicable, amount covered by insurance.
- Prescription claims MUST include the R_X number and pharmacy receipt, not cash register receipt.
- Allowable reimbursement for mileage expenses.

❑ **Dependent Care Reimbursement Account** **Total Amount Requested:**_____

Note: you MUST include the provider Tax ID Number in the service provider column in the table below. If you use the account to pay for the cost of a babysitter, you must provide the babysitter's Social Security Number. If you cannot remit a copy of your bill/contract, your daycare provider must sign on the line below in lieu of submitting a receipt.

Provider Signature: _____ **Date:** _____/_____/_____

❑ **Individual Premium Reimbursement Account** **Total Amount Requested:**_____

Note: please attach proof that employee owns policy.

❑ **Adoption Assistance Reimbursement Account** **Total Amount Requested:**_____

❑ **Parking Reimbursement Account** **Total Amount Requested:**_____

❑ **Transportation Reimbursement Account** **Total Amount Requested:**_____

❑ **Health Reimbursement Account** **Total Amount Requested:**_____

Date of Service	**E**mployee, **S**pouse or **D**ependent	Amount Requested	Type of Service (R_x, co-pay, dental expense, etc.)	Service Provider Number/ R_X Number
1.				
2.				
3.				
4.				
5.				

I certify that the above listed expenses have been incurred by me or by my spouse or dependent(s) and that they have not been reimbursed under any other health plan; furthermore, I will not seek reimbursement of the expenses under any other health plan.

Employee's Signature: _____ Date: ____/_____/_____

Revised 2/3/2012

CLAIM FORM

CLAIM SUBMISSION GUIDELINES

- Please number each receipt according to its order of appearance on this form.
- IRS guidelines do not consider cancelled checks as valid documentation.
- Previous balances are not acceptable.
- All reimbursements will be made payable to the employee.

SEND COMPLETED CLAIMS VIA FAX OR MAIL TO P&A GROUP

FAX: Toll-free (877) 855-7105 or (716) 855-7105
MAIL: Flex Department
17 Court Street, Suite 500
Buffalo, NY 14202-3204

P&A GROUP CUSTOMER SERVICE INFORMATION

Customer service representatives are available Monday- Friday, 8:30 AM- 8:00 PM ET.
WEBSITE: www.padmin.com
TOLL-FREE: (800) 688-2611

NEW! ELECTRONIC CLAIM SUBMISSION FEATURE NOW AVAILABLE!

Upload and submit your claims directly to the P&A website. Check out this latest update. Log into your account, click on the “Member Tools” tab and select the “Upload a Claim” option.