FlexibleBenefit ADMINISTRATORS

Ph: 800-437-FLEX or 757-340-4567
P.O.Box 8188 • Virginia Beach, VA 23450
www.flex-admin.com

Transaction Substantiation Form

How to File

Submit This Form OR the Benefits Card Letter

Please send (a) *this form* along with (b) *required documentation*.

Print Form

Form can be submitted by (1) e-mail, (2) fax or (3) mail.

To submit by e-mail, Print Form and sign. E-mail form along with receipts to benefitscard@flex-admin.com*

To submit by fax, Print Form and fax to: 757-431-1155

To submit by mail, Print Form and mail to: Flexible Benefit Administrators, Inc.
P.O.Box. 8188, Virginia Beach, VA 23450

Reminder:

- Do not mail your completed form if you fax it.
- Keep a copy of all completed forms and receipts for your records.
- Notify Flexible Benefit Administrators, Inc. if you have a change in address.

* E-mail will result in the quickest verification to your substantiation.

Employee Information

Employee's:

Print name

Social Security # or Employee ID:

E-Mail address **(For Notification of Processed Claims, Reimbursement & Account Status)**

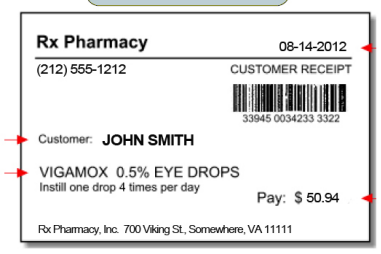
Employer

Expenses

	Date of Transaction	Name of Merchant	Type of Eligible Expense	$ Amount of Transaction
1				$
2				$
3				$
4				$

Total: $

Good Receipt



Receipt Missing Information

no description of items purchased

I, the participant, hereby certify that each expense was incurred on the date and for the reason noted. The expense(s) listed was incurred for medical care, not general health purposes, and excludes cosmetic and/or toiletry expenses. I, the participant, certify that I have not been reimbursed for the expense(s) noted above and that I will not seek reimbursement under any other plan covering health benefits. I, the participant, further certify that the expense(s) noted above has been paid for by use of my Benefits Card.

Attached are itemized receipts or bills to substantiate my Benefits Card transaction. I understand that I may NOT use this form to seek reimbursement for items paid out-of-pocket; I may do so by filing a Claim Form, found at www.flex-admin.com.

Please Note: A letter of medical necessity must be attached if the drug is considered a "dual purpose" item.

I authorize the service provider to release any information requested by the Plan Administrator in connection with this transaction.

Employee's Signature: Date:

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