

ATTN: FSA Department
P.O. Box 5689
Irvine, CA 92616
Phone: 888.289.4062 • Fax: 800.930.0437
E-mail: fsa@proviewbenefits.com
www.proviewbenefits.com/login/

INSTRUCTIONS:

- **Complete ALL SECTIONS** of this form to ensure timely payment.
- Submit the following documentation with this claim form:
 - The receipt, explanation of benefit (EOB), or invoice for the services rendered containing all of the following information:
 - The name of the person(s) for whom services were rendered and their relationship to you
 - The provider's name and address
 - The date range of the services rendered
 - A detailed description of the services
 - The amount due/paid

NOTE:

- Cancelled checks, credit card receipts, or balance due statements are **NOT** sufficient.
- If submitting prescriptions, please provide us a copy of the drug tag or pharmacy ledger.
- If you do not have insurance coverage for expenses submitted, you may select the option on your claim form indicating no coverage.
- You may send claims via any one of the following options: fax, e-mail, postal mail, or by logging onto your account at www.proviewbenefits.com/login/.
If faxing your claim, please indicate the number of pages included. Faxed claims must be legible for processing. # OF FAXED PAGES = _____.
If sending claims via e-mail, note that there is a 3MB size limit to e-mail attachments.

PART A: YOUR INFORMATION

EMPLOYER NAME			
EMPLOYEE NAME (First, Middle, Last)			SOCIAL SECURITY NUMBER (optional)
STREET ADDRESS		CITY	STATE ZIP
<input type="checkbox"/> NEW ADDRESS			
DAYTIME PHONE NUMBER (with area code) () -	EVENING PHONE NUMBER (with area code) () -	E-MAIL ADDRESS	

PART B: REIMBURSEMENT REQUEST

DATE(S) OF SERVICES RECEIVED (list date range) <i>*You may use one form for all health care expenses.</i>	
AMOUNT TO BE CONSIDERED UNDER THE HEALTH CARE REIMBURSEMENT ACCOUNT (GRAND TOTAL)	\$

Claims MUST be received by 12 Noon (PST) Wednesday to be considered for reimbursement on Friday.

PART C: EMPLOYEE STATEMENT

Mark all of the following statements that are applicable to the receipts you are submitting:

- _____ I am covered under an insurance plan (group or individual) or an employer sponsored employee benefits plan.
 _____ My explanation of benefits (EOBs) and applicable receipts are enclosed. *(EOB needed for most PPO plans including dental.)*
 _____ I am no longer an active employee of the above company. *(Please note that special conditions may apply for terminated employees; contact ProView for details.)*

I certify that these expenses for which reimbursement is claimed from my Flexible Spending Account have been received by me and/or my eligible dependents and have not been paid or is not payable by any other plan. I further declare that I have not and will not deduct these expenses on my federal, state, or local income tax returns.

Participant Signature

Date