PAYPROtpa.com
CA LIC. #0G76414

Reimbursement Request

FLEXIBLE SPENDING ACCOUNT

Please follow these instructions carefully
Missing or incorrect information may result in a delay of your reimbursement.

E-fax coversheet, Form, and claims to: 951.346.4244 - or -
Email Form and claims to: claims@PAYPROtpa.com

- Before faxing make sure your pages and cover sheet are placed in position with the proper side down or up.
- Please write clearly. We cannot pay a claim that is not legible.
- Include clear copies of your **itemized** receipts. Credit card payment slips do not have enough information and are not sufficient to approve your claim.
- You can go online to see if we've received your claim (we enter all claims within 72 hours of receipt). Paid claims will be viewable in your transaction history.
- To avoid delays, please complete all requested fields on this form.
- **REMEMBER, YOUR CLAIM MUST INCLUDE DATES OF SERVICE, DESCRIPTION OF SERVICES/ITEMS PURCHASED, PROVIDER INFORMATION, AND THE AMOUNT YOU ARE RESPONSIBLE TO PAY.**

Employee Information			
Employer Name			
Employee Name		Last 4 Digits of SSN	
Phone Number		Email Address	

Statement of Fact

I am submitting a claim under my employer sponsored reimbursement plan. I understand that the expense must be incurred in the current plan year, or subsequent extension if plan design allows; I understand that itemized receipts will be reviewed and must be legible; I agree that I will not seek reimbursement under any other plan for this expense; and I agree that I cannot use this expense as a deduction when filing my taxes. I further understand that funds that remain in the plan after the plan year ends (and subsequent plan year grace period) will be forfeited. This is known as the "use it or lose it" rule.

Total Number of Pages		Health Care FSA Total Claim Amount	$

Signature _____ Date _____

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