Preferred Health Plan
of the Carolinas

FLEX PLAN CLAIM FORM

Employer	Social Security #
Employee's Name (Last) (First) (MI)	

❑ PLEASE CHECK IF NEW ADDRESS

Street Address			Home Phone ( )
City	State	Zip Code	Work Phone ( )

EXPENSES BEING CLAIMED

PLEASE FILL OUT THIS FORM COMPLETELY

- Missing information will delay the processing of your claim.
- Attach all documentation to the back of this form. Keep copies, as these will not be returned.

Unreimbursed Medical, Dental or Vision Care

- If the expenses are eligible under your group health plan, include a copy of the Explanation of Benefits (EOB) or denial letter from your group health carrier.
- If the expenses are not generally covered by a group health plan, include a copy of the itemized bill showing dates(s) of service, services rendered, provider name and address, patient name, and charges.
- The insurance process must be complete for an expense to be eligible.

Description	Amount Requested

Dependent Childcare

A Paid receipt from your daycare provider must show

- Dates of service, from and through (mm/dd/yy – mm/dd/yy)
- Provider's Tax ID Number or Social Security number, name, phone, and address.
- Amount paid for services.
- Provider's signature.

Description	Amount Requested

READ CAREFULLY and PLEASE SIGN BELOW

I, the undersigned participant in the Plan, certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while I was covered under the Flexible Benefits Plan and that these expenses HAVE NOT BEEN reimbursed or are not reimbursable under any other benefit. I fully understand that I alone am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which I have provided. I understand that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes, fines, and penalties including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

Employee's Signature (Required):_____Date _____/_____/_____

Mail claims to:

Preferred Health Plan of the Carolinas
PO Box 749, Matthews, NC 28106
(866)636-0239 ext 305
(704)847-3014(fax)