

Debit Card Claim Form

Submittal of Receipts

Subject: Debit Card Receipts

Fax To: FlexSource, LLC

Mail To: FlexSource, LLC

Attn: Flex Unit

Attn: Flex Unit

Fax #: (630) 782-0644

P.O. Box: P.O. Box 828

Phone: (630) 782-0633

Elmhurst, IL 60126

Company Name

Full Name

Email Address

Work Phone Number

Debit Card Number

Attach copies of the Explanation of Benefits (EOB) from the insurance company with this cover sheet for all HRA Plans or a valid receipt from your provider that includes date of service, provider name & address, patient name, a description of service provided and dollar amount for all FSA Plans. Make sure you keep copies of your original receipts for your records.

Please submit this form with all faxed or mailed Debit Card Receipts.

Do not use this form when submitting manual claims.