PAYFLEX®

Flexible Spending Account Claim Form

ALASKACARE Health Plans

Mail or Fax completed form and documentation to:
PayFlex Systems USA, Inc.
PO Box 14879
Lexington, KY 40512-4879
Fax: 1-888-238-3539

Contact us at 800-416-7053 (TTY: 711)

To help avoid claim processing delays, you must sign, date and complete this form. You must also include supporting documentation.

WAIT! Did you know that you can file a claim online or by using the PayFlex Mobile® app?
To get started, log in to the mobile app or **payflex.com**, also accessible via Aetna Navigator®.
You can also find instructions online for completing this form.

Member Identification Number *(Social Security number)*	**Member Full Name** *(Last Name, First, MI)*
Member Address *(Street, City, State, ZIP Code)*	

Note: If you have an address change, please notify your employer. For security purposes, we can only accept an address change from your employer.

Employer Name

Health Care Expenses (For you, your spouse and your eligible dependents)

☐ **Automatic Monthly Reimbursement for Orthodontia expenses:** To set up automatic reimbursements, check this box. Include a copy of your orthodontia contract with this form. **Note**: For automatic monthly reimbursements, you only need to send this form and the contract once.

Patient Name	**Type of Service** (deductible, dental, medical, orthodontia, over the counter, pharmacy, vision)	**From Date of Service** (not payment date) MM/DD/YYYY	**To/Thru Date of Service** (not payment date) MM/DD/YYYY	**Amount Requested**
				$
				$
				$
				$
				$
				$
				$
****If more lines are needed, please complete another form.**			**Total**	**$ 0.00**

For Health Care Flexible Spending Account: I certify that I, my spouse or eligible dependent have incurred each expense on this form. These expenses are for eligible medical care. They are not for cosmetic reasons. I understand that "incurred" means the service has been provided.

I have not received reimbursement for any of these expenses. I will not seek reimbursement elsewhere, including from a Health Savings Account (HSA). If I receive reimbursement, I and (if married) my spouse will not claim these same expenses on our income tax return. I have received and read the printed material for the plan. I agree to all of the terms and conditions of the plan. Any person who, knowingly and with intent to defraud, files a statement of claim containing any material false, incomplete or misleading information is guilty of a crime.

Member Signature	**Date**

If you are mailing your claim, please keep a copy of this claim form and supporting documentation. We will not return these documents.