AdminUSA
Taking care of your business.

Claim Form

Today's Date _____/_____/_____ # of Pages _____ Plan year beginning for _____

☐ New Claim ☐ Resubmission of Claim ☐ Response to claim denial

Employer Name/Division Name:	Employee Name:	
Address: ☐ Please check if change of address		
Social Security Number:	Email Address:	Home Phone: Work Phone:

Please Note: Not all these accounts may apply to your group.

☐ Medical Expense Reimbursement Account **Total Amount Requested _____**

- Enclose insurance company statement or itemized bill from provider showing date of service, services rendered, provider of service, amount paid, and (if applicable) amount covered by insurance.
- Prescription claims MUST include the Rx number and pharmacy receipt, not cash register receipt.
- Allowable reimbursement for mileage expenses.

☐ Dependent Care Reimbursement Account **Total Amount Requested _____**

Must include provider Tax ID number.

Date of Service	Employee, Spouse or Dependent	Amount Requested	Type of Service (Ex: Rx, Copay, dental, etc.)	Service Provider / Rx # (MUST be provided)
1.				
2.				
3.				

If you are unsure if an expense is eligible for reimbursement, please call AdminUSA, Inc. at 1-866-993-7248 (Monday-Friday 8:00am to 5:00 pm EST). Please note the following requirements for claims submission:

- Please number each receipt according to its order of appearance on this form.
- IRS guidelines do NOT consider cancelled checks as valid documentation.
- Previous balances are NOT acceptable.
- All reimbursements will be made payable to the employee.

To the best of my knowledge and belief, my statements in this reimbursement voucher are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed on this or any other benefit plan and WILL NOT BE CLAIMED AS AN INCOME TAX DEDUCTION. I authorize my Flexible Compensation account be reduced by the amount released.

Employee's Signature _____ Date _____

For faster service, fax claims to (252) 265-5998 or mail to PO Box 8178, Wilson, NC 27893-1178 Attn: Dawn Montoya