



DeHEY McANDREW - FLEX SPENDING ACCOUNT Claim Form

Employer Name: [_____] Employee Name: [_____]
(Last First Middle)

Employee's Home Mailing Address: [_____] City: [_____] State: [_____] Zip: [_____]

Employee Social Security Number [_____] - [_____] - [_____] Daytime Telephone Number: (_____) [_____] - [_____]

This Claim Is For: [] Medical Spending [] Dependent Care Spending

Claims Information:

Name of Patient: (Last, First, Middle)	Relationship to Employee:	Amount Of Patient Responsibility:	Amount of Insurance Payment:	Date(s) of Service:	Date(s) of Service:	Type of Service: (Medical: Exam, RX drug, Eye Glasses, Co-Pay, etc.) (Dependent Care)	Name of Provider: (Medical: Doctor, Hospital, Lab, Pharmacy, etc.) (Dependent: Day Care, Individual Provider, etc.)
_____	_____	\$ _____	\$ _____	____/____/____	- ____/____/____	_____	_____
_____	_____	\$ _____	\$ _____	____/____/____	- ____/____/____	_____	_____
_____	_____	\$ _____	\$ _____	____/____/____	- ____/____/____	_____	_____
_____	_____	\$ _____	\$ _____	____/____/____	- ____/____/____	_____	_____
_____	_____	\$ _____	\$ _____	____/____/____	- ____/____/____	_____	_____
_____	_____	\$ _____	\$ _____	____/____/____	- ____/____/____	_____	_____
_____	_____	\$ _____	\$ _____	____/____/____	- ____/____/____	_____	_____
_____	_____	\$ _____	\$ _____	____/____/____	- ____/____/____	_____	_____

Complete This Section Only If You are Requesting **Scheduled Provider Payments** to be Made Directly to a Provider on scheduled basis.
I hereby authorize DeHEY McANDREW to pay the provider cited in this Section. I attest these services are ongoing and qualified.

Provider Name: _____ Address: _____ City: _____ State: _____ Zip: _____

Amount: \$ _____ • [] Monthly Payments [] Bi-Weekly Payments • Start Payments: ____/____/____ Stop Payments: ____/____/____

Claims Procedure:

1. Complete this form and attach an itemized Bill, Invoice, Receipt, Explanation of Benefits or other documented paperwork from your service provider.
2. **Mail To:** Claims Department, DeHEY McANDREW - PO Box 447 - Scranton, PA. 18501; OR, **Fax To:** (570) 346-3411.
3. I verify that the information that I have provided on this claim is accurate and that the expenses applied for herein are not a covered benefit on any existing Plan or reimbursable through any other Plan.

Signature: _____ • Date: ____/____/____