DM
DeHEY McANDREW

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.)
________________	____________	$_________	$_________	____/____/____ -	____/____/____	____________________	__________________
________________	____________	$_________	$_________	____/____/____ -	____/____/____	____________________	__________________
________________	____________	$_________	$_________	____/____/____ -	____/____/____	____________________	__________________
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________________	____________	$_________	$_________	____/____/____ -	____/____/____	____________________	__________________
________________	____________	$_________	$_________	____/____/____ -	____/____/____	____________________	__________________

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 - 101 South Main Avenue, Scranton, PA. 18504; 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: ________/__________/____________