FLEXIBLE BENEFITS PLAN CLAIM FORM
UNREIMBURSED MEDICAL CARE EXPENSES

To be reimbursed, please complete in full, sign/date and attach supporting documentation for every expense. Receipt must include patient name, type of service provided or drug name, date(s) of service and amount of patient responsibility. Over the counter (OTC) receipts must include the name or description of the eligible expense. IRS has determined a cancelled check or credit card statement is not sufficient documentation. An Explanation of Benefit (EOB) is considered proper documentation.

Please complete form in full, sign/date & attach supporting documentation for each expense.

Employee Information	Social Security Number	Full Name	Daytime Phone Number
Employer			Home Phone Number
Full Home Address			☐ **Check if New Address**
E-mail Address			☐ **Check if New E-mail Address**

*** You will receive notification by email when you claim is received and another when a payout is sent. You will also receive email notification of direct deposits. Be sure your email address is current and legible.**

Date(s) of Service **One expense per line.**	Medical Expense Description (i.e. Rx, copay, glasses, orthodontics, over-the-counter medication, etc.)	Relationship (self, spouse, child)	Amount Submitted
	TOTAL UNREIMBURSED MEDICAL EXPENSES INCURRED		**$**

Employee Certification

I certify I have incurred expenses for which reimbursement is claimed from the Flex Spending Account, and I further certify all medical expenses listed above and on any attached documents have not been reimbursed or will not be submitted for reimbursement from any other source. I also certify the above medical care expenses were incurred for the medical care of me, my spouse and/or qualified dependent. I acknowledge I am fully responsible for the accuracy of all information relating to this claim. If an expense for which I am reimbursed is later disallowed by the Internal Revenue Service, I understand I will be liable for payment of any related income or payroll taxes relating to such improper expense reimbursement.

Signature_____ **Date**_____

Claim Return Policy

If you submit a claim for an expense that is determined ineligible, for a time when you were not enrolled in the plan or submitted with insufficient documentation, PRN may request additional information to substantiate the claim. We will include an explanation of any corrective measures (if any) you must take before the claim can be processed. Please make necessary corrections and return the form. The claim will be processed on the next regularly scheduled processing date.

Claim Submission

PLEASE MAIL CLAIM FORMS AND SUPPORTING DOCUMENTATION TO:
Phillips Resource Network Flex Department, PO Box 653, Overland Park, KS 66201-0653
Telephone: 913.236.7777 Email: PRNS125@phillipsresource.com
Fax: 913.261-0083

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