centrix
BENEFIT ADMINISTRATORS

Medical Benefit Services
Request for Reimbursement Form/Section 125
Flexible Spending Account

Instructions: Please Print or Type the Information Below. **Benefit Services CLAIM FAX: (619) 220-9003**

Form can be submitted by (1) e-mail, (2) fax or (3) mail.
To submit by e-mail, Print Form and sign. E-mail form along with documentation to support@centrixba.com
To submit by fax, Print Form and fax to: (619) 220-9003
To submit by mail, Print Form and mail to: Centrix Benefit Administrators, Inc. P.O.Box. 212199, Chula Vista, CA 91921

Employee Information — Check here if address change

Participant's ID Number (Optional)			
Last Name	First Name	Middle Initial	Participant's E-Mail Address
Street Address	City	State	Zip

By submitting this claim form, I request reimbursement from my FSA account as listed below. I agree to the Terms and Conditions outlined in my employer's Summary Plan Description. I certify to Centrix Benefit Administrators these are eligible medical expenses that I or my dependents have incurred, are not cosmetic in nature, and cannot be reimbursed from any other source. I will maintain copies of all documentation for my records.

Participant's Signature: _____ Date: _____

Medical Reimbursement Claim Information

For Medical Care expenses, an Explanation of Benefits (EOB) from your insurance company or other receipt(s) must be submitted. **The EOB and/or attached bills must contain the following items in order to be processed and approved:**

1. Patient Name 2. Service Provider 3. Description of Service 4. Date(s) Service was Provided 5. Amount/Copay

List each receipt separately in the space(s) below. Use additional forms if necessary. A total must be indicated in the Total block below. Use the Provider Certification space below only if no receipt is attached. Do not indicate "see attached" in the spaces below.

Patient Name	Service Provider	Description of Service	Date Service was Provided	Requested Amount
			TOTAL $	

Provider Certification

In lieu of receipts or EOB(s) the Provider of the Service can certify that the above listed medical care expenses have been incurred and only incurred by either the participant of his/her dependents. Any other expenses must receipts or a separate completed form. Failure to complete all items will result in an invalid claim request.

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

Provider Signature: _____ Date: _____

** I certify that the Medical Care expenses listed above were incurred by the patient named above.