



Flexible Benefits  
 Health Care  
 Reimbursement Claim Form

**Instructions for Online Claim Filing**

- ▶ Claims may be filed online at [www.mgmflex.com](http://www.mgmflex.com). Log into your account and enter your claim information under the "File Claims" section.

**Instructions for Manual Claim Filing**

- ▶ Please print or type all information for manual claims request.
- ▶ Your Assigned Employee Number can be found on your participant website at [www.mgmflex.com](http://www.mgmflex.com)
- ▶ Attach copies of receipts, including date of service, patient name, provider information and amount of eligible expenses. **Do not submit original copies of receipts; they will not be returned.**
- ▶ Fax claims to (800) 973-3702.

**Employee Information**

Employer Name			Date
Last Name	First Name	MI	SSN <i>Or</i> Assigned Employee Number
Mailing Address		City	State Zip
<b>Email Address</b> <i>((Please print clearly - You will receive important emails regarding claims and payments on your Flexible Plan Accounts))</i>			Contact Phone Number

I certify that the expenses listed below were incurred by me or my eligible dependents during the applicable plan year and qualify for reimbursement. The reimbursements requested have not been reimbursed or reimbursable from any other source. I understand that I may be requested to provide additional explanation for the requested reimbursements, and it is my responsibility to maintain copies of all documentation for my records. I fully understand that I am responsible for the accuracy of all information relating to the claim provided.

\_\_\_\_\_

Signature of Participant

\_\_\_\_\_

Date Signed

**Medical FSA Claim Information**

*Please keep your original receipts for your records. Attach copies of bills, receipts or other evidence of eligible out-of-pocket expenses for reimbursement. For expenses to be reimbursed from a Group Insurance Carrier, please attach an Explanation of Benefits (EOB). Canceled checks and credit card receipts are not considered sufficient documentation.*

Date Service Incurred	Patient Name	Provider Name	Description of Service <small>(e.g., RX, co-pay, dental, office visits, etc.)</small>	Amount Requested
<b>Total Requested</b>				