Flexible Benefits Claim Form

Email to: Flex@hnq.com
Fax to: 866-600-7398 or 225-644-9985

Employee Last Name ____________ *First Name* ____________ *MI* ____

Spouse Name ____________ *Dependent(s) Name(s)* ____________

Address ____________ *Address Line 2* ____________

City ____________ *State* ____ *Zip* ____

E-Mail Address ____________ *Telephone* ____________

Employer ____________

Social Security Number: ☐☐☐ – ☐☐ – ☐☐☐☐ *Employee ID Number:* ____________

In order to receive reimbursement, copies of supporting documentation must be attached. Please include copies of an itemized bill from the provider listing exact dates of service (balance forward statements are not acceptable), service performed and cost or an Explanation of Benefits (EOB) from your insurance company listing service dates, service performed and cost. Please retain a copy of this claim form and supporting documentation for your records, as we are unable to return original documents to you. Cancelled checks do not qualify as a supporting document.

DO NOT SEND IN CLAIMS UNTIL THEY TOTAL A MINIMUM OF $5.00

Service Date	Paid to	Drug Name (if prescription)	Procedure Code	Amount

PROCEDURE CODE — M = Medical D = Dental P = Prescription
I = Insurance Premium V = Vision O = Other

FOR OFFICE USE ONLY
_____Notified of ineligible Expense

To request reimbursement, please complete this form, including appropriate documentation and provide signatures where required.

I certify that all listed expenses have not been reimbursed by any other source, nor will they be reimbursed by any other source. In addition, I certify that these expenses were incurred for eligible members of my family or me, and they have not been reimbursed from any other health insurance coverage.

SIGNED____________________ **DATE** ____________