Please send this form along with all applicable receipts to:
1200 River Ave, Suite 10E, Lakewood, NJ 08701
Fax: 877-747-8564
E-Mail: Claims@flexfacts.com

HRA Claim Form

Personal Information

Full Name: ____
Last *First* *M.I.*

Employer: ____

Last Four Digits of Your Social Security Number ______________________

Phone: ( ) ______________________ E-mail: ______________________

If your address has changed please list the new address below.

New Address: ____

City, State, Zip ____

Claim Information

Please enter the claim details below

Date of Expense: ______________________ Amount: ______________

Date of Expense: ______________________ Amount: ______________

Date of Expense: ______________________ Amount: ______________

Date of Expense: ______________________ Amount: ______________

Date of Expense: ______________________ Amount: ______________

Date of Expense: ______________________ Amount: ______________

Pay Provider? Yes ☐ No ☐ Provider Name ______________ Address______________________,

Employee Certification

Employee Signature: ____

Date: ____

- By signing this form I agree to have my account reduced by the amount requested.
- This claim for reimbursement is only for expenses incurred by eligible plan participants during the plan year.
- These expenses have not been reimbursed nor will I seek reimbursement for these expenses from any other source.
- If additional information is required you will receive a denial letter letting you know what additional information is needed.