



≤ <u>forms@wexhealth.com</u>

Claim Form

the following information: (1)		, ,		•) and (4) Name of provider	
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*Required Fields									
							-	- - - - - - - - - - - - -	
*Participant Name (First, MI, Last)							*Social Security Number		
*Employer Name (Do not abb	reviate)					1	Employee ID		
Claim Reimbursement Inform	ŕ						. ,		
		*5			- 10			to . (D.) . (
	*Service Dates (start and end dates		*Provider Name		Type of Service (i.e. Rx, Co-Pay, Dental)			*Out-of-Pocket Cost (i.e. Patient Responsibility)	
*Plan Types: HFSA-Health FSA; HRA-I	Health Reimburseme	ent Arrangement					Total: \$		
Claim Information – Depende	nt Care ESA on	ly (no receipt needed y	when submit	ting a provider's sign	nature)				
*Service Dates		ovider Name	wiich Subiiii	*Provider's Signat	,	*Daycare Cost			
-]				\$			
Doutining at Contification									
Participant Certification To the best of my knowledge, the	provided informa	stion in complete and see	roto Loortifus	that the requests I am a	auhmitting a	ro oli	igible evnence ee defi	and by the IPS and that I have not	
been previously reimbursed for the or another purpose not permitted if submitting expenses for my De I must attach to my federal income for whom I am requesting reimburduring the month in which I did not individual for whom I am request C (Medicare Advantage) during the month in the I did not individual for whom I am request C (Medicare Advantage) during the month in the I did not individual for whom I am request C (Medicare Advantage) during the month in the I did not individual for whom I am request C (Medicare Advantage) during the I did not individual for whom I am request C (Medicare Advantage) during the I did not individual for whom I am request C (Medicare Advantage) during the I did not individual for whom I am request C (Medicare Advantage)	nese expenses no d under the IRS ru pendent Care Acc le tax return. If su rsement, contint or have MEC will b ing reimbursemer he month the exp suant to the terms	or am I seeking reimbursei iles. I understand that Wi count, I have obtained or r ibmitting expenses for my e to have Minimum Essen become taxable. If submit nt, have (or had) individue ense was incurred. If ther s of the plan, benefit paym	ment from any EX, including it made reasonal Qualified Smattal Coverage (ting expenses at health insurare are any char	other source. I also ce is agents and employed ble efforts to obtain the all Employer Health Rei (MEC). I understand th for my Individual Cover ance coverage, Medica ages in the provided inf	rtify that expes, will not be provider's Tembursement at if I fail to rage Health I re Part A (Heformation, I uterity)	pense e hele Tax II t Arra main Reim ospit unde	es were incurred for po d liable if I submit ineli D (TIN) and I will includ angement (QSEHRA), tain MEC, any reimbur abursement Arrangemi tal Insurance) and B (N rstand it is my respons		
Submit Claims									
Fax to:	66-451-3245 WEX		Email to:				ile online:		
866-451-3245			forms@	wexhealth.com			efitslogin.wexhe		
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