Spending Account Claim Form

OREGON HOMECARE WORKERS SUPPLEMENTAL TRUST

HOMECARE WORKER Supplemental & Benefits Trusts

Participant: _____

Social Security #: _____

Telephone: _____

Email: _____

ACCOUNT TYPE	Date Expense Incurred	Amount Requested
Example:		
Out-of-Pocket, Deductible, Copays, and/or Rx Reimbursement		
Premium Reimbursement		

INSTRUCTIONS

Please read carefully and be sure your claim is completed in its entirety to ensure there is no delay in processing. Please do not use a highlighter on the claim form, receipts, or any other documents included as backup as this may cause a delay in processing your claim.

1) Complete all applicable sections, sign and date. Services must be incurred in order to be reimbursed.
2) Attach all required documentation (*For an OTC medicine, please include a copy of your medical provider's prescription or a pharmacy receipt showing the prescription #).*
3) Mail, fax, or email the completed claim form (*scanned with signature if necessary*) to Ameriflex.
4) Please allow 2–3 weeks for paper check delivery or 7–10 days for direct deposits from the processing date.

To avoid delays in reimbursement, please sign and date this claim form and provide notice of any name or address change to Ameriflex.
I authorize my account(s) to be reduced by the amount requested. To the best of my knowledge and belief, the statements on this form are complete and true. I am claiming reimbursement only for eligible expenses incurred by eligible plan participants during the applicable plan year. I certify that these expenses have not previously been reimbursed by this or any other benefit plan, will not be reimbursed from any other source, and will not be claimed as an income tax deduction. I also understand that I may be asked to provide further details (*i.e., a letter of medical necessity from a medical practitioner certifying that the expense is to treat or cure a medical condition or a more detailed certification from me*).

Participant Signature **Date**

Please mail, fax, or email this form to: **Ameriflex Claims Department** P.O. Box 269009, Plano, TX 75026
Fax: 888.631.1038 Attention: Claims Department **Email:** claims@myameriflex.com