Individual Coverage HRA Substantiation Request Form

Ameriflex

Instructions: In order for medical care expenses to be eligible for payment with your individual coverage health reimbursement arrangement (HRA) Convenience card, you must complete this form for each Convenience card transaction.

The individual coverage HRA Convenience card may be used for a medical care expense incurred during a month only if you have (or had) individual health insurance coverage, Medicare Part A (Hospital Insurance) and B (Medical Insurance), or Medicare Part C (Medicare Advantage) during that month. Similarly, the individual coverage HRA Convenience card may be used for a medical care expense your family member incurred during a month only if the family member has (or had) individual health insurance coverage, Medicare Part A and B, or Medicare Part C during that month. In this form, you are attesting that you (or your family member) meet this requirement.

You must sign and date this form. Your family member does not need to sign or date the form. **Please complete both pages of this form.**

Complete the following if you used your individual coverage HRA Convenience card to pay for a medical care expense and are submitting documentation to verify this expense.

I attest to the following:

I, _____, used my individual coverage HRA Convenience card to
(insert name)
pay for a medical care expense incurred during _____, and for that month I am
(insert month, year)
(or was) covered under the following health coverage:_____.
(insert name of insurance company or indicate “Medicare”)

Instructions: Complete the following if the individual coverage HRA Convenience card was used to pay for a family member’s medical care expense and you are submitting documentation to verify this expense.

I, _____, used my individual coverage HRA Convenience card to pay for
(insert name)
a medical care expense incurred by _____, during
(insert name of family member)
_____, and for that month this family member is (or was) covered under the
(insert month, year)

following health coverage: _____.
(insert name of insurance company or indicate “Medicare”)

I hereby affirm that the above information is true and accurate.

Signed: _____

Date: _____

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Employer Name:_____

Employee Name:_____ Telephone: _____

Employee Address: _____

City:_____ State: _____ Zip:_____

Email: _____

Member ID (which may be your SSN):_____

Please check box if the above information reflects a change of address: ☐

Date of expense: _____

Type of Expense:

☐ Prescription

☐ Copay

☐ Vision

☐ Dental

☐ Other: _____

Proof of Expense Attached ☐ Yes ☐ No

If you are unable to provide a receipt or if the expense is ineligible, please attach a check or money order made out to Ameriflex to reimburse your account. Failure to provide proper documentation for an eligible expense or to reimburse your plan for an ineligible expense can result in the termination of your AmeriFlex Convenience Card and your plan.

To the best of my knowledge and belief, the above statements are complete and true. I certify all of the following: Either I or my eligible dependent has received the services described above on the dates indicated; the expense(s) qualify as valid Medical expenses under my plan; if the expense is for my spouse/dependent, that person is my spouse or dependent as defined by my plan; I have not been and will not be reimbursed by any other source for this expense.

Employee Signature Date

Email: claims@myameriflex.com
Fax: 888.631.1038 Attn: Claims Department
Mail: Ameriflex Claims Department
P.O. Box 269009
Plano, TX 75025

Please do not send original documents. If damaged or lost during processing, they cannot be replaced.