IntegraFlex
An Industry Leader in Consumer-Driven Healthcare Solutions

FSA, 213(d) HRA & QSEHRA Claim Instructions

Important: Estimates for services that have not yet been incurred ***cannot*** be accepted. Be sure to keep a copy of your documentation on file at all times.

Documentation Instructions:

IRS acceptable forms of supporting documentation are one (1) of the following:

- Itemized Billing Statement from the Daycare Provider showing the following detail:
  1. Name of Provider and Address; along with their EIN or SSN
  2. Name of Dependent
  3. Services rendered
  4. Date of Service
  5. Billed amount
- Claims Itemization Summary Report from your Dental, Medical or Vision Insurance Carrier
- Explanation of Benefits (EOB) from your Dental, Medical or Vision Insurance Carrier

Individual Health Premium Note for QSEHRAs: You will need to submit a Copy of the Schedule /Declaration Page from your insurance company showing the following detail.

- Insurance is Billed to your Home Address
- Include the Valid Dates of Coverage
- Monthly Dollar Amount Paid for Coverage

Note: You will need to submit a new Schedule/Declaration Page each new Plan Year.

Note: Individual Health Premium claims can only be paid with funds that are currently available in your QSEHRA at the time of the claim. The balance of the claim will continue to release as your employer contributes more funds to your account each month.

Claim submission methods: Upload, fax or email your completed contract to IntegraFlex

- Sign In to the IntegraFlex Employee Portal – https://integraflex.wealthcareportal.com to upload your Dependent Care Claim Form with your supporting documentation.
- Fax to: (855) 673-6711
- Email to: claims@integra-flex.com

Employee | FSA / 213(d) HRA / QSEHRA Claim Form

I.F. IntegraFlex

EMPLOYEE INFORMATION

Employer | Date

Employee Name | SSN

Phone Number | Email

Home Address | ☐ Check if New Address

FLEXIBLE SPENDING ACCOUNT/HEALTH REIMBURSEMENT ARRANGEMENT

CLAIM ATTACHMENTS – Failure to follow these guidelines will result in reimbursement delay or possible denial.

REQUIREMENTS:

*An ***"Itemized Statement"*** from the provider **MUST** be submitted showing:
- Provider's Name/Address
- Patient's Name
- **"Actual"** Date of Service when the Service was Provided
- Description of Service & the Amount Charged

*An Explanation of Benefit (EOB) from your Insurance Carrier

*Claims Itemization Report from your Insurance Carrier.

***NOTE:** The Left Three (3) Forms of Documentation **ARE** the **ONLY** Forms of Documentation that **ARE** Acceptable under **IRS** Guidelines.
- Balance forward or paid on account statements **CANNOT** be accepted.
- Credit card receipts, cancelled checks, or cash register receipts **CANNOT** be accepted for services.
- Itemized cash register receipts are Only acceptable for over-the-counter medications.

-Estimates for services that have not yet been incurred **CANNOT** be accepted.

(please check method of payment)

Service Date	Name of Provider *(e.g. Physician, Dentist Hospital, Pharmacy, Insurance Carrier, etc)*	Type of Service *(e.g. Copay, Rx, Ortho, Insurance Premium, etc.)*	Patient Name	Expense Amount	Recurring Expense	NOT Paid w/ Flex Debit Card	Paid w/ Flex Debit Card

Total amount requested from your **FSA/Cafeteria Plan** $ _____

AND/OR

HRA $ _____

* Please List Manual Reimbursement Requested Amounts Only–*Paid for service other than with your IntegraFlex Benefits Card.*

I certify that I have actually incurred these eligible expenses. I understand that expense incurred means the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed or are not reimbursable from any other source. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions.

Employee's Signature **Date**