Transaction Substantiation Request

Employer Name: _____

Employee Name: _____ **Telephone:** _____

Employee Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Social Security Number: _____

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 (see statement below)

Is this a recurring expense? ☐ Yes ☐ No (If "Yes", you do not need to substantiate this expense moving forward)

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**

Send completed form to:

Email
claims@myameriflex.com

Fax
888.631.1038
Attention: Claims Department

Mail
Ameriflex Claims Department
P.O. Box 269009
Plano, TX 75026

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