Get your money faster.

Submit your claim online or via mobile app.

Skip this manual claim form and submit your claim electronically. You have two options:

ASIFlex Online

Go to ASIFlex.com to register and set up your online account. Once registered, you can view your account statement, submit claims, read secure messages, and manage your personal account settings.

ASIFlex Mobile App

Search ASIFlex Self Service on Google Play or the App Store to download the app. Use your login credentials to sign in. Just snap a picture of your claim documentation and submit claims through the app.

You can also check your account balance.

How to Submit Claims

Attach appropriate documentation of your expenses

IRS guidelines require specific documentation to substantiate each claim submission. This includes:

❶ Explanation of Benefits (EOB) from your insurance plan. This document is sent to you after the plan processes your claim and shows the amount paid by the plan and the amount for which you are responsible; or,

❷ Itemized statement from your health care provider. This **must** show specific information:

- ✓ Provider name and address;
- ✓ Patient name;
- ✓ Date service was provided (not date of payment);
- ✓ Description of each service provided; and
- ✓ Dollar amount you owe.

For prescriptions: Submit the pharmacy receipt, printout from your pharmacy, or itemized mail-order receipt.

For over-the-counter health care products, drugs and medicines: Submit the merchant's itemized cash register receipt.

For dependent care expenses: Submit an itemized statement of the services provided or have your provider sign the claim form to certify the services provided.

For orthodontia: Submit the monthly payment coupon or an itemized statement and payment receipt if claiming one upfront payment (if allowed by your employer's plan). Otherwise, a contract and proof of payment will be needed.

Please **do not** submit credit card receipts, paid on account or balance forward statements, or cancelled checks.

Fax or mail completed claim form with documentation

ASIFlex
PO Box 6044
Columbia, MO 65205-6044
FAX 1.877.879.9038

Keep a copy of your documentation and claim form for your records.

Flexible Spending Account (FSA) Claim Form

Your Name (Last, First, MI)	Social Security No. or EID or PIN	Your Employer's Name

Address	City	State	Zip Code

Dependent Care Flexible Spending Account Claims

Follow the instructions on page 1 and submit correct documentation or have your provider sign below to certify the care provided.

Name of Dependent	Age	Dates Care Was Provided No Future Dates MM/DD/YY thru MM/DD/YY	①Name/Address of Care Provider or Care Facility ②Type of Dependent Care Service (Daycare, Day Camp, Preschool, After School Care, etc.)		Amount Requested
			①		$
			②		
			①		$
			②		
			①		$
			②		
				Total	$

* Day Care Provider or Care Facility Certification:	* Day Care Provider or Care Facility Certification:
I certify that I provided dependent care services as detailed above.	**I certify that I provided dependent care services as detailed above.**
Print Name: _____	Print Name: _____
Original Signature: _____	Original Signature: _____
Date: _____	Date: _____

Health Care Flexible Spending Account Claims

Follow the instructions on page 1 and submit correct documentation to ensure rapid processing.

Date(s) of Service	Health Care Provider	Type of Expense (Office Visit, Crown, Eyeglasses, Rx, etc.)	Patient Name	Relationship to You	Amount Requested
					$
					$
					$
					$
					$
					$
					$
				Total	$

I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by me, an eligible spouse, or an eligible dependent during a period while I was covered under my employer's FSA Plan; and that the expenses have not been reimbursed, and reimbursement will not be sought from any other source. I certify any claimed dependent care expenses are work-related to allow me and, if married, my spouse to work, are primarily for the protection and well-being of my dependent, and were provided for my dependent under the age of 13, or for my dependent who is incapable of self-care. I certify that any claimed dependent care expenses are not for overnight camps, lessons, or classes to learn a specific skill or sport, or for educational sessions or classes. I understand that I am fully responsible for the accuracy of all information relating to this claim, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. A claim will only be processed with a completed and signed claim form and correct documentation. Claims are not accepted by email due to privacy/security concerns.

✓ Employee Signature _____ Date _____

FAX TO: 1-877-879-9038
PAGE_____OF _____
NO COVER PAGE NEEDED

MAIL TO: ASIFLEX
PO BOX 6044
COLUMBIA, MO 65205-6044

FILE ONLINE WWW.ASIFLEX.COM OR VIA MOBILE APP
NO CLAIM FORM NEEDED!
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