Flexible Spending Account Claim Form

Varipro
BENEFIT ADMINISTRATORS

Please print all information

Participant Information

Employer: ______________________ **Daytime Phone #:** (   )   -

Participant Name: ______________________ **Social Security #:** ____________

Address: ______________________ ☐ **Check if new address**

Participant E-mail Address: ______________________ ☐ **Check if new email address**

Certification for Disbursement:

To the best of my knowledge and belief, this Reimbursement Request Form is complete and true. I certify that my family member or myself received the services described above on the date indicated and that the expense(s) qualify as a valid expense under the Plan. If the expense is for my spouse or dependent, I certify that the person's meets the definition of spouse/dependent under the Plan. I understand that these expenses may not be used to claim any federal income tax deduction or credit. I understand that I am fully responsible for the sufficiency, accuracy and validity of all information relating to this claim, and may be liable for payment of all related taxes (federal, state, city) that may be due for an invalid claim. For healthcare expenses, I certify that these expenses are not eligible, and have not been reimbursed, under any other health plan. For dependent care expenses, I agree to file IRS Form 2441 with my tax return and provide any taxpayer identification number required thereon. ACCEPTANCE OF FACSIMILE OR SCANNED SIGNATURES: Document signatures delivered by facsimile or email/pdf are valid and enforceable. Such facsimile or scanned signatures shall have the same force and effect as an original signature.

______________________ ______________________

Participant Signature *(Required)* **Date**

Unreimbursed Medical Expenses – *You must attach an Explanation of Benefits or itemized receipts for each service*

Debit Card Purchase		Patient Name/ Relationship	Dates of Service Start	End	Description of Service	Requested Amount
☐ Yes	☐ No	____________ ☐ Spouse ☐ Child ☐ Other:________	/ /	/ /	☐ Prescriptions ☐ Copay/Deductible ☐ Other Medical Services (lab, surgery, etc.) ☐ Dental/Orthodontia ☐ Vision/Hearing ☐ Mileage ☐ Other: ____________	$
☐ Yes	☐ No	____________ ☐ Spouse ☐ Child ☐ Other:________	/ /	/ /	☐ Prescriptions ☐ Copay/Deductible ☐ Other Medical Services (lab, surgery, etc.) ☐ Dental/Orthodontia ☐ Vision/Hearing ☐ Mileage ☐ Other: ____________	$
☐ Yes	☐ No	____________ ☐ Spouse ☐ Child ☐ Other:________	/ /	/ /	☐ Prescriptions ☐ Copay/Deductible ☐ Other Medical Services (lab, surgery, etc.) ☐ Dental/Orthodontia ☐ Vision/Hearing ☐ Mileage ☐ Other: ____________	$
☐ Yes	☐ No	____________ ☐ Spouse ☐ Child ☐ Other:________	/ /	/ /	☐ Prescriptions ☐ Copay/Deductible ☐ Other Medical Services (lab, surgery, etc.) ☐ Dental/Orthodontia ☐ Vision/Hearing ☐ Mileage ☐ Other: ____________	$
					Total Reimbursement Requested:	$

Dependent Care Expenses – *You must attach itemized receipts for each service*

Dependent Name/ Relationship	Dependent DOB	Provider Name	Provider Tax ID or SSN	Dates of Service Start	End	Requested Amount
____________ ☐ Spouse ☐ Child ☐ Other:________	/ /			/ /	/ /	$
____________ ☐ Spouse ☐ Child ☐ Other:________	/ /			/ /	/ /	$
____________ ☐ Spouse ☐ Child ☐ Other:________	/ /			/ /	/ /	$
					Total Reimbursement Requested:	$

How to Submit Claims

Electronically:
Online: www.member.varipro.com
Mobile App: Varipro Health Cloud app
Email: flex@varipro.com

By FAX:
FAX Number: 844-902-4564
Number of Pages: ____________

By Mail:
Varipro
5300 Patterson Ave SE, Suite 150
Grand Rapids, MI 49512

Customer Service: 800-732-3412

For fastest results, file online at www.member.varipro.com or by using the Varipro Health Cloud app (available in both the Apple App and the Google Play Stores).

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