



VitaFlex Medical Expense Claim Form

Employee Data

Company Name:	Vita
Employee Name:	Jane Smith
Employee Social Security or ID Number:	123-45-6789

Grace Period

Please indicate in which Plan Year election the below outlined claim(s) should be processed.

<input checked="" type="checkbox"/> 2007 Plan Year Election	<input type="checkbox"/> 2008 Plan Year Election
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Reimbursement Request

Complete the following grid for each medical expense submitted for reimbursement. In order to receive reimbursement, appropriate supporting documentation must accompany this form. Please refer to the VitaFlex Information and Instructions or your Plan Information to confirm necessary documentation, timing requirements, and rules for eligible expenses. You can also visit our website at www.vitaflex.net.

Patient Name	Relationship to Employee	Date of Service	Name of Service Provider	Description of Medical Expense	Amount of Claim	Debit Card?*
Jane Smith	Self	02/19/07	PAMF	Copay	\$ 15	<input type="checkbox"/>
					\$	<input type="checkbox"/>
					\$	<input type="checkbox"/>
					\$	<input type="checkbox"/>
					\$	<input type="checkbox"/>
					\$	<input type="checkbox"/>

*Check box if receipts submitted are intended to document purchases already made with your **VitaFlex** debit card.

Verification

To the best of my knowledge and belief, the statements in this medical expense claim form are complete and true. I certify these claims are for valid medical expenses provided on the dates indicated and that these expenses were incurred while I was actively participating in the VitaFlex Medical Reimbursement Plan. *These expenses have not been reimbursed under the VitaFlex plan previously nor have they been reimbursed under any other health plan. Additionally, I will not submit these expenses for reimbursement under any insurance plan or from any other source.* I understand that these expenses may not be used to claim any federal income tax deduction or credit. I understand that I alone am responsible for the sufficiency, accuracy and validity of all information relating to this claim. If any claim for reimbursement is not an eligible expense under the plan, I will be responsible for payment of all related liabilities, including federal and state income taxes and any applicable penalties resulting from improper reimbursement from the plan.

05/04/07	<i>Jane Smith</i>
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Date

Employee Signature

New Phone/Address (Complete Only if Needed)

New Preferred Phone Number:	()
New Email Address:	
New Home Address:	

A photocopy of this form may be used if additional copies are needed.

For fastest service, fax claims to 650-964-FLEX (3539) or email claims to claims@vitamail.com.

PALO ALTO MEDICAL FOUNDATION

Camino Division
Business Services 408-524-4100
P.O. Box 3757 Sunnyvale, CA 94088-3757

PLEASE KEEP THIS RECEIPT FOR YOUR RECORDS

Guarantor: 408765

MRN: 8509530

Alt MRN: 736288

Patient: Smith, Jane

567 Palm St

Mountain View, CA
94040

Appt#: 19586457

Provider: GUPTA MD, NIRAJ

Date: 02/19/07

Batch: 225467

Amount: \$15.00

Received By: MAGTOTC

Payment Type: COPAY CHECK

Invoice: 57808664

Comment: chk#1026

This provider receipt is sufficient for a co-pay reimbursement because it contains all the necessary information:

- 1) Provider's name
- 2) Patient's name
- 3) Type of service
- 4) Total cost of service
- 5) Date of service