



# VitaFlex Medical Expense Claim Form

## Employee Data

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

## Grace Period

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

<input checked="" type="checkbox"/> <b>2007 Plan Year Election</b>	<input type="checkbox"/> <b>2008 Plan Year Election</b>
--	---

## 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](http://www.vitaflex.net).

Patient Name	Relationship to Employee	Date of Service	Name of Service Provider	Description of Medical Expense	Amount of Claim	Debit Card?*
John Smith	Child	03/31/07	Mtn. View Opt	Vision	\$772-	<input checked="" 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.

04/21/07	Jane Smith
----------	------------

Date

Employee Signature

## New Phone/Address (Complete Only if Needed)

<b>New Preferred Phone Number:</b>	(       )
<b>New Email Address:</b>	
<b>New Home Address:</b>	

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](mailto:claims@vitamail.com).

**VISION CARE BENEFIT REIMBURSEMENT**

GROUP : VITA  
 NUMBER : 2579-045  
 CLAIM NO. : 65895411 00

**DATE OF SERVICE: 03-13-07**

**DOCTOR : MTN. VIEW OPTOMETRY**  
 SSN or ID : 000-00-\*\*\*\*

EMPLOYEE : JANE SMITH  
 EMPLOYEE SSN : 123-45-\*\*\*\*

CHECK DATE : 04/18/07

**PATIENT : JOHN SMITH** REL : CHILD

CHECK NO : 031578556 258

<b>SERVICE</b>	<b>EXPENSES SUBMITTED</b>	<b>DEDUCTIBLE</b>	<b>BALANCE CONSIDERED</b>	<b>MAXIMUM ALLOWED</b>	<b>DATE SERVICE AVAILABLE</b>	<b>VSP PAYMENT</b>	<b>PATIENT PAYS</b>
<b>LENSES</b>	\$529.00	\$25.00	\$504.00	\$45.00		\$45.00	\$484.00
<b>FRAMES</b>	\$349.00	\$0.00	\$349.00	\$61.00		\$61.00	\$288.00
<b>TOTAL</b>	<b>\$878.00</b>	<b>\$25.00</b>	<b>\$853.00</b>	<b>\$106.00</b>		<b>\$106.00</b>	<b>\$772.00</b>

According to your plan’s reimbursement schedule, the amount of this check represents your maximum reimbursement entitlement. Services, denoting “NC” indicates your plan does not cover that service.

If you believe our determination to be incorrect, you have the right to request an appeal. To appeal a determination and receive assistance, call our Customer Service Department at 1-800-877-7195 within 180 days from the date of this notice, or write to VSP, Quality Satisfaction Unit, PO Box 997100, Sacramento, CA 95899-7100.

Did you know that when you visit a VSP network doctor there is no claim paperwork for you to handle and your satisfaction is guaranteed? With VSP and our network of doctors, it’s easy as 1-2-3.

- Find a VSP network doctor at [vsp.com](http://vsp.com) or call 1-800-877-7195.
- Next time you make an appointment, tell the doctor you are a VSP member.
- Your doctor and VSP will handle the rest.

And when you visit a VSP network doctor, your coverage will go further, and you will receive great savings, discounts, and personalized service.

This statement is sufficient for a vision claim because it contains all the necessary information:

- 1) Provider's name
- 2) Patient's name
- 3) Type of service
- 4) Date of service
- 5) Insurance coverage
- 6) Total out-of-pocket cost

You may also submit a statement from the vision provider, but please note that vision claims must be submitted to all other forms of insurance before being eligible for reimbursement from your FSA plan. If no plan benefit was available at the time of service, please submit a copy of your benefit eligibility. If you do not have vision insurance, please contact our office to let us know.