Payroll Management
Medical Flexible Spending Account
Claim Form

Remit To:
125Admin.com
Attn: Payroll Management
10716 Carmel Commons Blvd. Ste 150
Charlotte, NC 28226
Fax: 888-923-9977
Email: claimprocessing@125admin.com

Employee Information

Employer Name:						Daytime Phone:	
Employee Name:						SSN #:	
Employee Address:						Apt/Suite:	
City:		State:		Zip:		E-Mail:	

PLEASE NOTE: Claims that are not listed on this form cannot be processed. You must complete each field below for each claim you are seeking reimbursement for and attached supporting documentation.

Unreimbursed Medical Expenses *(Attach supporting documentation)*

Supporting documentation for unreimbursed medical expenses must include all of the following:

- Provider's name and address
- Service Description
- Date of Service
- Patients name
- Amount Billed

Date(s) of Service	Amount	Description of Service	Provider / Merchant Name	Name of Person Receiving Service

Employee Confirmation

I certify that the claims listed above are a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and were incurred while I was covered under the Flexible Spending Account(s). Supporting documentation from my service provider(s) for all expenses is attached to this claim form. I understand that I cannot claim any reimbursed expenses from the plan on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax and any associated penalties on the amounts paid for any expense improperly claimed under the provisions of the Flexible Spending Account(s).

Employee's Signature: ____ **Date Signed (mm-dd-yyyy):** __________________________

Internal Use Only: **Date Received:** _____________________ **Date Entered:** ________________________