How to File a Claim

Please mail or fax your claims to the address below:

CBIZ Payroll
Attn: Flex Claims Administrator
P.O. Box 20
Roanoke, VA 24002
Fax: 540.345.3666
Phone : 800-815-3023
Option #4

If mailing your claim, please allow plenty of time for the postal service to deliver your claim. All completed claims must be received by Thursday at 2:00 PM EST to be processed and mailed on Friday.

Completed claims consist of:

1. **A completed and signed claim form.** This is the authorization to disburse money from your account. *(Please be sure to include Employer, Name, and S.S.N.)*

2. Any claim must be accompanied by receipts that include amounts charged, date of services and a description of service or item provided, and for whom they were provided. **IRS regulations do not permit monthly statements, debit card receipts, credit card receipts or cancelled checks as proof of service.**

Please be sure to call our processing center if:

1. You do not receive a disbursement check within 15 days of mailing a claim to us.
2. You have any change in address.
3. You have any questions regarding payments received.

For checks that are sent to the wrong address, lost, stolen, or mishandled, a stop payment can be issued 14 days past the check date for a service charge of $25.00.

Limited FSA Claim Form

Employer:	**Email Address:**
Employee Name:	
SocSec #: - -	**Contact Number: ( ) -**
Email Address:	
Home Address: ☐ **Check if address has changed**	

Health FSA Preventive Services; Dental, Vision & Post Deductible Services Only

Date of Service	Name and Address of Service Provider	Type of Expense	Person for Whom Expense Paid	Amount Paid
			Total Claim	$

Read Carefully

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the company's Flexible Benefits Plan with respect to such expenses, and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, and or local income tax on amounts paid from the Plan which relate to such expense.

Employee Signature _____ **Date** _____

Mail or fax Claim Form and Receipts to:
CBIZ Payroll, Inc.
P.O. Box 20
Roanoke, VA 24002
Fax: 540-345-3666
Phone: 800-815-3023 option #4
Email Address: cbizflex@cbiz.com

myflexonline.com
Check your account balace here!!