BENEFITS CLAIM FORM

CBIZ Human Capital Management

Instructions for Quick Claims Processing:

1. Fully complete & sign the claim form
2. Attach copies of supporting EOB, receipts, bills, etc.
3. All receipts must include: date of service, description of service and amount of service
4. Please list one expense per line
5. Please print legibly in black or blue ink when using this form
6. Please allow at least 2 business days from receipt for claims to be processed

For Account Balance:
Go to myplans.cbiz.com
Or call (800) 815-3023, option 4

WAIT!

Would you like your claim processed faster? Did you know you can file claims online or through our Mobile App?
Log in to the consumer portal at myplans.cbiz.com and select File a Claim under the Accounts link.
Download the Mobile App through the AppStore or Google Play and search for "My Plans by CBIZ."

PERSONAL INFORMATION

Employee Name (First Name, Last Name) _____

Employer Name _____

Phone Number _____

Email Address _____

Social Security Number _____

CLAIM INFORMATION

Date Expense Incurred	Service Provider*	Service	Individual Receiving Service	Plan Type (DC, FSA, HRA, or Parking)	Amount

Total: $ 0.00

*If submitting a Dependent Care Claim, please include the Tax Identification number and ensure your provider has signed under Provider's Signature in lieu of any receipts.

Provider's Signature _____

Healthcare FSA: I, the undersigned, certify that I, my spouse, or eligible dependent have incurred each expense on this form. These expenses are for eligible medical care and are not for cosmetic purposes. I understand that "incurred" means the service has been provided.
Dependent Care FSA: I, the undersigned, certify that I have incurred the Dependent Care expenses for me and, if married, my spouse to work. These expenses are for my Qualifying Dependent. These qualify as eligible expenses under my plan and are not for educational expenses to attend kindergarten or higher. I understand that "incurred" means the service has been provided. These are regardless of when I am billed or charged for, or pay for the service.
Parking FSA: I, the undersigned, certify that I have incurred each expense on this form, and are eligible expenses under my plan.
HRA: I, the undersigned, certify that I, my spouse, or eligible dependent have incurred each expense on this form. These expenses are eligible under my plan. I understand "incurred" means the service has been provided.

I understand that if any information is missing or incorrect on the claim form or supporting documents the claim will be denied and must be resubmitted with the corrected/missing information. I certify that I have not received prior reimbursement for any of these expenses and I will not seek reimbursement elsewhere, including from a Health Savings Account (HSA). If I receive reimbursement, I and (if married) my spouse will not claim these same expenses on our income tax return.

Employee Signature _____ **Date** _____

Claim Form may be mailed, faxed, or emailed

2797 Frontage Road NW, Suite 2000, Roanoke, VA 24017 | Fax (800) 584-4185 | cbizflex@cbiz.com

If you are mailing your claim form, please keep a copy of the claim form and supporting documents for your records; CBIZ will not return.