



# Washington Flex Claim Form

Please read the instructions and requirements on the back before completing this form.

Name (Last, First, MI):		Social Security Number:	
Home Address (Street, City, State, Zip Code):			
Daytime Phone:		Home Phone:	

## Unreimbursed Medical Benefits

Date medical care or treatments received*	Provider name	General description of medical expense (include medical condition for over-the counter items)	Patient name	Relationship to employee	Amount that is your responsibility	ASI use only
<b>Total Amount Requested</b> →						

↑  
 Please attach your documentation in the order listed under **Date medical care or treatments received.**

**\*ASIFlex will not accept claims for future services or treatments. See Orthodontics on the back of this form for exceptions.**

I certify that all expenses listed above are accurate and were incurred while enrolled in Washington Flex. I will not seek reimbursement of these expenses from any other source. If ASIFlex reimburses me for any expense listed above that does not qualify for reimbursement, I understand I may be liable for repaying the total amount to ASIFlex.

Employee signature \_\_\_\_\_ Date \_\_\_\_\_

Return completed form to ASIFlex at 1-866-381-9682 (toll-free fax), P.O. Box 6044, Columbia, MO 65205-6044 or via email to [claims@asiflex.com](mailto:claims@asiflex.com) (PLEASE SEE EMAIL FILING REQUIREMENTS ON THE NEXT PAGE). **You must include supporting documentation.**

**Questions? Call ASI toll-free at 1-800-659-3035 or send an e-mail to [asi@asiflex.com](mailto:asi@asiflex.com).**

## Claim Filing Requirements

1. **Complete the employee information.** Print your name, Social Security number, home address, and daytime and home phone numbers.
2. **Complete the Unreimbursed Medical Benefits table.** List expenses by date. If you have several statements from the same provider, you may add your totals together on one line with a range of service dates.
3. **Enclose your supporting documents, arranged in the same order listed in the Unreimbursed Medical Benefits table.** You must either provide a written statement from the medical provider (doctor, hospital, pharmacy, etc.) who provided the service or treatment **or** the Explanation of Benefits from your health insurance company showing all of the following:
  - The provider's name.
  - The date(s) when medical services or treatments were provided. Although this may be the same date as the date you paid, the document must clearly show the date the service/treatment was provided. (Circle these dates on your documents.)
  - A description of the service provided (for example, dental cleaning).
  - The patient's name.
  - The cost of the service, not just the amount you paid.

If you file a claim without these documents, ASIFlex cannot process it and will return it to you.

4. Sign and date the claim form.
5. Keep copies for your tax records.
6. Return your claim form and documents to ASIFlex by fax at 1-866-381-9682 (toll-free) or

**Mail Claims to:**  
ASIFlex  
P.O. Box 6044  
Columbia, MO 65205-6044

**Email Claims requirements:**  
1) Attachment must be in PDF or tif format  
2) Only one file attachment  
3) Must indicate in the subject line of the email that a claim is attached.  
4) Must send to [claims@asiflex.com](mailto:claims@asiflex.com)

## Reminders

**Over-the-counter drugs and treatments:** You do not have to send a statement from your provider or health insurance company (see exception below for vitamins, herbs, and nutritional supplements). Along with a completed claim form, you must provide:

- A receipt or documentation from the store, which must include the name of the drug printed on the receipt. The store must provide this information; you cannot write it on the receipt.
- You must provide the existing or imminent medical condition on the receipt, the claim form, or on a separate statement each time you claim reimbursement for this item. ASIFlex will not accept claims for general good health items.

**Medical equipment, vitamins, herbs, nutritional supplements, health club memberships, weight-loss programs, massage therapy, and purchases or services normally deemed cosmetic:** To file a claim for these items, you must have a note from your provider stating:

- The nature of your medical condition.
- The specific service or item needed.
- The service/item is needed for the treatment of your condition.

**Orthodontics:** You may only file claims for orthodontia **after** the braces are placed and while treatment is in process. To claim orthodontic down payments, you must include a copy of the treatment contract and payment schedule **and** proof of payment showing the date the braces were placed. To claim a monthly payment, you must either include a paid receipt from your orthodontist **or** a copy of the monthly payment coupon and your check. See the *Washington Flex Enrollment Guide* for details.