BENEFITS CLAIM FORM



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 Service Provider* Incurred	Service	Individual Receiving Service	Plan Type DC, FSA, HRA, or Parking	Amount
			Total:	
*If submitting a Dependent Care Claim, ple ensure your provider has signed under			re	
Healthcare FSA: I, the undersigned, certify that I, for cosmetic purposes. I understand that "incurred Dependent Care FSA: I, the undersigned, certify to Dependent. These qualify as eligible expenses unhas been provided. These are regardless of when Parking FSA: I, the undersigned, certify that I hav HRA: I, the undersigned, certify that I, my spouse, means the service has been provided. I understand that if any information is missing or interest and the service has been provided.	d" means the service has been p hat I have incurred the Depender der my plan and are not for educ I am billed or charged for, or pay e incurred each expense on this or eligible dependent have incur	provided. In the Care expenses for me and, if married, my speciational expenses to attend kindergarten or high of for the service. Form, and are eligible expenses under my plan. These expenses on this form. These expenses	ouse to work. These expenses are ler. I understand that "incurred" m	for my Qualifying neans the service erstand "incurred"
information. I certify that I have not received prior (HSA). If I receive reimbursement, I and (if married Employee Signature	reimbursement for any of these	expenses and I will not seek reimbursement els		

Claim Form may be mailed, faxed, or emailed