

Transaction Substantiation (Claim) Form

Employer: _____
Employee Name: _____
Employee Address: _____
City: _____ State: ____ Zip: _____
Email Address: _____
Employee Social Security Number: _____ - _____ - _____
Please check box if above information reflects a change of address or email:

Date of Expense: _____

Name of Claimant: _____

Relationship to Employee: _____

Type of Expense:

- Prescription Co-pay X ray & Lab Office Visit Physical Exam
 Out-Patient Surgery In-Patient Hospital Emergency Room Other _____

Please attach the Explanation of Benefits (EOB) from your Insurance Company. No reimbursements can be made without an EOB.

To the best of my knowledge and belief, the above statements are complete and true. I certify all of the following:
Either I or my eligible dependent has received the services described above on the dates indicated; the expense(s) qualify as valid medical expenses under my plan and I have not been and will not be reimbursed by any other source for this expense.

Employee Signature: _____ Date: _____

**Send to: Pacific Benefits iFlex, Inc. 3090 Fite Circle, Ste. 101, Sacramento, CA 95827 or Fax to: (916) 363-4213;
Phone: (916) 363-2101**