Claim Form: FSA Medical Recurring Expense

This form is used to request ongoing reimbursement from your Flexible Spending Account (FSA) for recurring, eligible medical expenses. By completing this form, you will not need to provide continuing documentation. Please complete all fields and include appropriate documentation showing the expenses you will be charged throughout the year or during specific time frames.

All information must be completed for you to receive reimbursement.
CLAIMS WILL NOT BE PROCESSED WITHOUT YOUR SIGNATURE

A. DECLARATION OF SERVICES

I request reimbursement for the below listed time frame for FSA-qualified medical care services. I certify that the expenses are for dates of service between the following:

Start Date (mm/dd/yyyy) _____ End Date _____

I have included signed copies of the provider's charges, in the total amount of $ _____ for the dates indicated above.

Note: If you have any changes during the dates referenced above, please notify:

ZyneraHealth **Phone: 855-572-7200** **Email: claims@zynera.com**

B. EMPLOYEE/PARTICIPANT INFORMATION

Employer Name (Please Print) _____

Employee/Participant Name _____

Address _____

Social Security Number _____ Mobile Phone _____ Work Phone _____

Participant Email Address _____

C. PROVIDER INFORMATION

Name of Service Provider _____

Name of Claimant (Person Receiving Service) _____

Provider Address _____

Provider Account/Claim Number (if applicable) _____

D. CERTIFICATION AND SIGNATURE

I certify that the expenses for reimbursement indicated on this substantiation form were incurred by me (and/or my spouse and/or eligible dependents) and were not reimbursed by any other plan, nor will I seek reimbursement from any other source. To the best of my knowledge and belief, the expenses are eligible for reimbursement under my Flexible Spending Account (FSA). I (or We) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee/Participant Signature _____ Date _____
mm/dd/yyyy

For fastest processing: Fax: 409-291-5064 **Email: claims@zynera.com**

PLEASE USE YOUR EMAIL PROVIDER'S ENCRYPTION FEATURES TO SEND YOUR EMAIL SECURELY