# Flexible Spending Account Claim Form

**Mail or Fax completed form and documentation to:**
**Inspira Financial**
**PO Box 2495**
**Omaha, NE 68103**
**Fax: 888-238-3539**

**Contact us at 800-416-7053 (TTY: 711)**


**To help avoid claim processing delays, you must sign, date and complete this form. You must also include supporting documentation.**
**WAIT! Did you know that you can file a claim online or by using the Inspira Financial Mobile® app?**
To get started, log in to the mobile app or inspirafinancial.com, also accessible via Aetna Navigator®.
You can also find instructions online for completing this form.

| **Member Identification Number** *(Social Security number)* | **Member Full Name** *(Last Name, First, MI)* |
|---|---|
| **Member Address** *(Street, City, State, ZIP Code)* | |

**Note**: If you have an address change, please notify your employer. For security purposes, we can only accept an address change from your employer.

| **Employer Name** |
|---|

**Health Care Expenses** (For you, your spouse and your eligible dependents)

☐ **Automatic Monthly Reimbursement for Orthodontia expenses:** To set up automatic reimbursements, check this box. Include a copy of your orthodontia contract with this form. **Note**: For automatic monthly reimbursements, you only need to send this form and the contract once.

| **Patient Name** | **Type of Service** (deductible, dental, medical, orthodontia, over the counter, pharmacy, vision) | **From Date of Service** (not payment date) MM/DD/YYYY | **To/Thru Date of Service** (not payment date) MM/DD/YYYY | **Amount Requested** |
|---|---|---|---|---|
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| ****If more lines are needed, please complete another form.** | | | **Total** | **$** 0.00 |

**For Health Care Flexible Spending Account**: I certify that I, my spouse or eligible dependent have incurred each expense on this form. These expenses are for eligible medical care. They are not for cosmetic reasons. I understand that "incurred" means the service has been provided.

I have not received reimbursement for any of these expenses. 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. I have received and read the printed material for the plan. I agree to all of the terms and conditions of the plan. Any person who, knowingly and with intent to defraud, files a statement of claim containing any material false, incomplete or misleading information is guilty of a crime.

I understand that state laws may prohibit the reimbursement of certain expenses and I certify this reimbursement claim and any related documentation provided complies with my state's law regarding the reimbursement of expenses for certain services.

| **Member Signature** | **Date** |
|---|---|
| | |

**If you are mailing your claim, please keep a copy of this claim form and supporting documentation. We will not return these documents.**