Please visit www.abpmtpa.com for additional forms.

MEDICAL EXPENSE FLEX CLAIM FORM

(USE THIS FORM TO SUBMIT CLAIMS BY FAX OR MAIL)

FAX: 406-523-3149 or **TOLL FREE FAX:** 877-424-3539

PHONE: 406-721-2222 or **TOLL FREE PHONE:** 877-424-3570

Return FAX # ____________________________
Return Phone # ____________________________

PAGES: ________ including this cover sheet

MEDICAL EXPENSE REIMBURSEMENT REQUEST

Please use black or dark blue ink. Do not use highlighter or gel pens. Do not include dependent care expenses on this form..

Company: ____

Employee Name: _______________________________________ SSN: __________________________

List eligible medical, dental or vision services and expenses for you and your family that you have not already claimed through flex. Only list the amount of the expense you have to pay **after insurance** pays its share. Insurance premiums, deducted by your employer, are NOT eligible.

Services Listed	Service Date	Covered By Insurance?	Out-of Pocket Expense
______________________________	__________	Y N	$ ________________
______________________________	__________	Y N	$ ________________
______________________________	__________	Y N	$ ________________
______________________________	__________	Y N	$ ________________

YOU MUST SUBMIT INDEPENDENT, 3RD-PARTY DOCUMENTATION OF YOUR EXPENSES WITH THIS CLAIM FORM. IF ANY OF THESE EXPENSES WERE COVERED BY INSURANCE, ATTACH A COPY OF THE "EXPLANATION OF BENEFITS" FROM YOUR INSURANCE COMPANY AS DOCUMENTATION. FOR EXPENSES NOT COVERED BY INSURANCE, SEND A COPY OF A BILL OR INVOICE IDENTIFYING THE SERVICE, SERVICE DATE, TOTAL CHARGES AND ANY DISCOUNTS. IF THE REQUIRED DOCUMENTATION IS NOT ATTACHED, YOUR REIMBURSEMENT WILL BE DELAYED.

I certify that these statements are true and that the claimed expenses cover only myself, my tax dependents, and/or spouse (if filing taxes jointly). I further understand that expenses reimbursed by FLEX may not be claimed on my individual tax return at the end of the year.

Employee Signature: __________________________________ Date: ________________________

Check here if your address has changed. Please list below.

New Address: ____________________________________

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