# <u>MO Cafe</u>

Get your money faster. Submit your claim online or via mobile app.

Skip this manual claim form and submit your claim electronically. You have two options:

## **ASIFlex Online**

Go to ASIFlex.com to register and set up your online account. Once registered, you can view your account statement, submit claims, read secure messages, and manage your personal account settings.

## **ASIFlex Mobile App**

Search ASIFlex Self Service on Google Play or the App Store to download the app. Use your login credentials to sign in. Just snap a picture of your claim documentation and submit claims through the app.

You can also check your account balance.



# How to Submit Claims



# Attach appropriate documentation of your expenses

IRS guidelines require specific documentation to substantiate each claim submission. This includes:

• Explanation of Benefits (EOB) from your insurance plan. This document is sent to you after the plan processes your claim and shows the amount paid by the plan and the amount for which you are responsible; or,

**2** Itemized statement from your health care provider. This **must** show specific information:

- ✓ Provider name and address;
- ✓ Patient name;
- ✓ Date service was provided (not date of payment);
- ✓ Description of each service provided; and
- ✓ Dollar amount you owe.

<u>For prescriptions</u>: Submit the pharmacy receipt, printout from your pharmacy, or itemized mail-order receipt.

For over-the-counter health care products, drugs and medicines: Submit the merchant's itemized cash register receipt.

<u>For dependent care expenses</u>: Submit an itemized statement of the services provided or have your provider sign the claim form to certify the services provided.

<u>For orthodontia</u>: Submit the monthly payment coupon or an itemized statement and payment receipt. Otherwise, a contract and proof of payment will be needed.

Please <u>do not</u> submit credit card receipts, paid on account or balance forward statements, or cancelled checks.

# Fax or mail completed claim form with documentation

ASIFlex PO Box 6044 Columbia, MO 65205-6044 FAX 1.877.879.9038

Keep a copy of your documentation and claim form for your records.





Your Name (Last, First, MI)	Social Security	No. or EID or PIN	Your Employer's Name			
			STATE OF MISSOURI			
Address		City		State	Zip Code	

### **Dependent Care Flexible Spending Account Claims**

#### Follow the instructions on page 1 and submit correct documentation or have your provider sign below to certify the care provided.

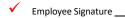
Name of Dependent	Age	Dates Care Was Provided <u>No Future Dates</u> MM/DD/YY thru MM/DD/YY	Dates (2) Type of Dependent Care Service			Amount Requested		
			1			<i>.</i>		
		-	2			\$		
			1			ć		
			2			Ş		
			1			ć		
			2			Ş		
					Total	\$		
* Day Care Provider or Care Facility Certification:			*	* Day Care Provider or Care Facility Certification:				
I certify that I provided dependent care services as detailed above.		I	I certify that I provided dependent care services as detailed above.					
Print Name:		F	Print Name:					
Original Signature:		0	Original Signature:					
Date:			Date:					

### **Health Care Flexible Spending Account Claims**

#### Follow the instructions on page 1 and submit correct documentation to ensure rapid processing.

Date(s) of Service	Health Care Provider	Type of Expense (Office Visit, Crown, Eyeglasses, Rx, etc.)	Patient Name	Relationship to You	Amount Requested
					\$
					\$
					\$
					\$
					\$
					\$
					\$
				Total	Ś

I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by me, an eligible spouse, or an eligible dependent during a period while I was covered under my employer's FSA Plan; and that the expenses have not been reimbursed, and reimbursement will not be sought from any other source. I certify any claimed dependent care expenses are work-related to allow me and, if married, my spouse to work, are primarily for the protection and well-being of my dependent, and were provided for my dependent under the age of 13, or for my dependent who is incapable of self-care. I certify that any claimed dependent care expenses are not for overnight camps, lessons, or classes to learn a specific skill or sport, or for educational sessions or classes. I understand that I am fully responsible for the accuracy of all information relating to this claim, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. A claim will only be processed with a completed and signed claim form and correct documentation. Claims are not accepted by email due to privacy/security concerns.



FAX TO: 1-877-879-9038 PAGE\_\_\_\_\_OF\_\_\_\_ NO COVER PAGE NEEDED MAIL TO: ASIFLEX PO BOX 6044 COLUMBIA, MO 65205-6044 Date