Claim Form — Flexible Spending Account — 2025

Clear Form

Use this form to submit for reimbursement of eligible medical, dental, vision, dependent care and over-the-counter (OTC) expenses.

Employer/Company Name	***Department/Division***	***HPI Member ID# and/or Employee SSN***
Employee Last Name	***First Name (Subscriber)***	***MI*** / ***Date of Birth***
Mailing Address	***City*** / ***ST*** / ***ZIP Code***	
Email Address	***Primary Phone#***	***Alternate Phone#***

Instructions

For reimbursable expenses that were part of a medical, dental or vision claim, attach copies of insurance explanation of benefits, claims, bills, receipts or payment forms. For reimbursable OTC expenses, please attach a copy of the original receipt or order confirmation. Vitamins /supplements, homeopathic remedies, massage therapy, weight loss programs/ drugs and gym memberships require a doctor's note of medical necessity. Items not eligible for reimbursement include transactions through a collection agency, weight loss foods, toothbrushes, insurance premiums, marriage counseling and cosmetic surgery.

Receipts/invoices must include the following:

- the date of service or date the expense was incurred
- the name and address of the service/product provider
- a description of the expense or the specific OTC item purchased *(i.e., the product name, quantity and/or size, if applicable*)
- the name and Social Security Number of the member who received the services/product
- the amount of the charges

In the absence of a detailed receipt, please provide corroborating documentation, such as a copy of the product packaging with identifying information that matches a line item on the available receipt (*e.g.*, the UPC code number).

Date of Service ***(MM/DD/YYYY)***	**Name & Address of Service/Product Provided**	**Describe Expense**	**Member Name**	**Member SSN**	**Net Amount**
					$
					$
					$
					$
					$
					$
					$

CLAIM TOTAL $ 0.00

Please Read Carefully

The undersigned Plan Participant (Subscriber) certifies that all expenses claimed herein were incurred during a period of active coverage. The undersigned understands that he or she is fully responsible for the sufficiency, accuracy and veracity of all information contained herein, and that if an expense claimed herein is not an eligible expense under the plan, the undersigned may be liable for the payment of all related taxes (including federal, state or city income tax) on amounts paid by the plan which relate to said expense.

I certify that all items claimed herein comply with the Flexible Spending Account program, and said items have not and will not be covered by any other plan or program of any employer, or other party, and will not be reimbursed through a rebate program.

Signature: _____ _____

Signature of Employee *Date Signed*

Print and submit this form to:

HPI
Attn: Flexible Spending Dept.
PO Box 5199
Westborough, MA 01581

or fax to: 508-329-4815

Please retain a copy of this form and all related documentation for your records.

Questions? Give us a call at 877-734-7004, or submit your question online at hpiTPA.com; just click on Contact.