



FLEX CARD DOCUMENTATION COVER SHEET

This is for the submission of documentation to substantiate Flex Card transactions ONLY!
You will not be reimbursed for these expenses.

EMPLOYEE INFORMATION *(Please Print)*

Name: _____
SSN: _____
Employer: _____
Day Phone: _____
Email : _____

Does your documentation include all of the following?

Provider's Name and Address	Patient's Name
Service Description	Amount Charged
Date of Service	

**** Credit card receipts are not acceptable ****

Date of charge	Claim #	Name of Provider	Amount

Mail To: myCafeteriaPlan, 432 East Pearl St., Miamisburg, OH 45342
Fax To: 937.865.6502 **Email To:** claims@myCafeteriaPlan.com

To contact Customer Service, call 800.865.6543

Access your account information 24 hours a day, seven days a week on our web site: www.myCafeteriaPlan.com