# Flexible Spending Account Claim Form

Do not use for expenses already paid with your FSA card

Name of Employer:

Telephone Number

Employee's Name:

Total Health Care Reimbursement Requested:

Email Address:

Total Dependent Care Reimbursement Requested:

Social Security Number:

Dependent Care Tax ID:

Mailing Address:

| Date of Service | Provider Name | Description | Amount |
|---|---|---|---|
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |

Employee's Signature: Date:

PLEASE ATTACH ALL RECEIPTS AND PROOF OF EXPENSES TO THIS FORM!

Mail to:
**Section 125 Claims Deparatment**
**Paragon Benefits**
P.O. Box 12288 Columbus, GA 31917
Phone: 1.800.277.9218

Fax: 1.706.256.4023
Email: flex@paragonbenefits.com
For Claims Inquiries Call: 1.866.661.5078