DELTA
CONSUMER DIRECTED
HEALTH PLANS

Flexible Spending Account

Claim Form

Please mail completed form to:
Delta Health Systems
3244 Brookside Rd, Suite 109
Stockton, CA 95219
Toll free: 888-478-7331
Email: flex@delapro.com
or Fax: 801-412-8542

Please review the claim form instructions on our website, www.hrbenefitsdirect.com/delta, or email flex@delapro.com to eliminate delay with the processing of your claim.

Complete the appropriate spaces on this form and attach the Explanation of Benefits or proof of expenses, which includes provider's name, date of service, type of services provided, and pharmacy leaflet. Check registers, bank statements, and credit card receipts are not valid forms of proof of service. Please refer to your Summary Plan Document for timeframes and guidelines on claims submission.

Employer: _____ **Group #:** _____

Employee Name: _____ **Social Security Number:** _____

Address: _____ **Empl #:** _____ **Site:** _____

City: _____ **State:** _____ **Zip:** _____

Telephone Number: _____ **Email Address:** _____

TYPE OF EXPENSE(S)

Date(s) of Service FROM	TO	Individual Receiving Service	Service Type (Office Visit, RX, Dental, Vision, etc.)	Amount
				$
				$
				$
				$
			Total Amount Requested for Reimbursement	$

FOR DEPENDENT CARE PROVIDER / COMPLETED BY PARTICIPANT

Date(s) of Service FROM	TO	Dependent Receiving Service	Age	Provider	Provider Tax ID	Amount
						$
						$
					Total Amount Requested for Reimbursement	$

Provider Address: _____ **Provider Phone #:** _____

Provider Statement: Provider's signature is required if no receipt is attached, verifying that childcare services were provided for the amount and dates indicated above.

Provider Signature: _____ **Date:** _____

I, the undersigned, request reimbursement for the eligible expenses listed for myself and/or any eligible dependents. I certify these expenses are eligible for reimbursement under the Flexible Spending Account sponsored by my employer. I have not been and will not be reimbursed for these expenses from this or any other benefit plan and have/will not included them as itemized deductions or as a tax credit on mypersonal income tax returns.

Employee Signature: _____ **Date:** _____

Note: Claim will be rejected if supporting documentation is not received and the form is not signed.

A copy of our privacy notice can be found online at www.deltahealthsystems.com/privacy.