PAYCHEX®

Paychex Benefit Account (PBA) Reimbursement Claim
Unreimbursed Medical Expenses

Submit or View claims:
Online: https://paychexflex.com
**All claim reimbursements will be processed within 3 business days upon receipt of the completed claim form and all supporting documentation.

Employer Name ____

Employee Name & DOB ____

CLAIM INFORMATION
I certify that the information here is true and correct; that the expenses incurred were for myself, my spouse as defined by federal law, or my eligible dependents; and that these expenses are not reimbursable under any other health plan coverage.

Employee Signature: ____**Date**: ____________________

Name of Recipient*	**Relationship to Employee**	Service Date(s)	**Paychex Debit Card Used? Y/N**	**Service Description**	**Service Provider**	**Cost of Service**	**# of Miles****
Sample: John Doe	☐ Self ☐ Spouse ☑ Dependent	07/07/07	Y	☐Med ☐ Dental ☐ Vision ☐Pharmacy ☑ Mileage	Dr. Jones	$521.43	5
	☐ Self ☐ Spouse ☐ Dependent			☐Med ☐ Dental ☐ Vision ☐Pharmacy ☐ Mileage			
	☐ Self ☐ Spouse ☐ Dependent			☐Med ☐ Dental ☐ Vision ☐Pharmacy ☐ Mileage			
	☐ Self ☐ Spouse ☐ Dependent			☐Med ☐ Dental ☐ Vision ☐Pharmacy ☐ Mileage			
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	☐ Self ☐ Spouse ☐ Dependent			☐Med ☐ Dental ☐ Vision ☐Pharmacy ☐ Mileage			
	☐ Self ☐ Spouse ☐ Dependent			☐Med ☐ Dental ☐ Vision ☐Pharmacy ☐ Mileage			
					Total:		

☐Enclose copies of all itemized bills, or Explanation of Benefits (EOB) from your provider.
☐Verify that bills and receipts contain: ~date of service, ~provider's name, ~description of service, ~cost of service
☐Sign your claim form and retain a copy of our itemized bill for your records
☐ **fax** this claim form and supporting documentation to 585-389-7003

****Please do not lump dates of services together. Use additional claim forms.**
**** Mileage will be calculated at the time of processing**