900 S Capital of TX Hwy, Ste 350
Austin, TX 78746
Phone # (800) 943-9179
Fax # (888) 989-9247
Email: 125@tcgservices.com

Reasons For Claim Denial:
1 –Form is missing required information
2 –Invalid/No proof of purchase (credit card receipt not acceptable)
3 –Service/Item not covered by plan

Reasons For Claim Denial:
4 –Expense(s) incurred outside plan year
5 –Reimbursement period has expired
6 –Your account is Maxed Out
7—Services rendered unknown

Medical Flex Spending Claim Form

*Items in **Bold** below must be filled in for the claim to be processed. If any information is deemed incomplete the form and accompanying receipts will be returned.*

Participant Name:_____ **Participant SSN**: _____

Street Address: _____ **Employer Name**:_____

City, State Zip: _____ Home/Mobile Phone:_____

Email Address: _____

***NOTE:** If you have more expenses than can fit on this one form then you must fill out a second form in full and submit your supporting documentation as if it were a second claim.*

Does your receipt include ***ALL*** of the following?

☐ Provider's name & address ☐ Date of Service ☐ Amount Billed

☐ Service Description ☐ Patient's Name ☐ Amount Paid

FSA Out-of-Pocket Medical or Dental Expenses: Please attach legible copies of paid receipts **and** Explanation of Benefits (EOBs) showing the portion of the expenses, if any, paid by your Employer's Group Medical or Dental Plan. **Credit card slips alone are not acceptable forms of documentation**

Note: If you received your claim form back with a *Denied* line item, please resubmit, unless *Claim Denial* reason is number 6 above, the denied claim item on a new claim form with the appropriate substantiation.

ADMINISTRATOR USE ONLY

Name of Person for whom the Expense was incurred	Relationship (Participant, spouse, child, qualified dependent)	Name of Merchant	Date(s) of Service	Amount Paid (out-of-pocket only)	Amount Approved	Amount Denied	Denied Reason (See Above)
			TOTALS:				

If any of these expenses are covered by Medicare or another Group Medical or Dental Plan (not including your Employer's), provide the following:

Name of Group Medical/Dental Plan Company:_____

Name of Insured under the Plan listed above:_____

Further explanation if *Other* provided for Denial Reason:

_____

_____

I certify that the expenses listed above have been incurred by me, my spouse or my dependents during this Plan Year and qualify for reimbursement under this Plan. (See Page 2 of your Employer's 125 Plan Booklet for a description of eligible expenses). I also understand that these expenses no longer qualify as tax deductions or credits. The paid bills, receipts or other proof of these expenses are attached. I hereby authorize any physician, hospital, or other organization or person having any records, data, or information concerning health history or other insurance for my minor dependents, or me, to furnish such records, data, or information as may be requested by my Employer and/or TCG Administrators.

PARTICIPANT SIGNATURE:_____ ***DATE:*** _____