TPA Systems Inc.

P.O. Box 262502, Houston, Texas 77207

Health Reimbursement (HRA)/Flexible Spending (FSA)/HSA/Dependent Care Claim Filing Instructions

Use this form as your fax cover page! fax to: 713-641-4721 number of pages including this form: _____

Submit this claim form to our office, either by fax or by email at claims@tpasystems.net. Submit this form along with one of the following:

1. If your company's reimbursement plan reimburses out-of-pocket expenses tied to your employer's health insurance plan, you must submit copies of your Explanations of Benefits (EOB) from your health insurance company. EOB's are routinely provided by your insurance company after the claims process has begun. EOB's are mailed to your residence address, but are usually available more quickly if obtained online through your insurance company.

2. If your company's reimbursement plan reimburses eligible expenses without regard to whether they are tied to an EOB obtained from your employer's health plan, then you must submit copies of your receipts for your eligible expenses.

Important: be sure to specify the correct last and first name of the patient for whom expenses are being claimed on, if the patient and the employee are not the same person (as in the case of covered dependents). By far, the safest and fastest way to file claims is by fax, but almost any legible form is acceptable. However, you must include either patient EOB's from your health insurer or receipts for your eligible expenses in order to receive a reimbursement. **Important - you cannot recover reimbursements without complying with either item # 1 or item # 2 above! Make sure your claim form is complete! Leave no spaces blank! If you have more than one EOB or receipt for your medical procedures, be sure to include all of them.** For questions regarding the claims process, please call 713-641-4720.

The preferred method that TPA Systems Inc. uses for claims reimbursement is electronic funds transfer; your funds are deposited directly into your bank account. Accordingly, please include a voided check from your bank account when filing a claim. ***This is a very safe transaction***. If you prefer to receive your reimbursement by regular mail, we will deduct $7.00 from your otherwise eligible reimbursement to cover printing costs, postage, and handling.

Employer name: _____ Filer email address: _____

Employee (EE) last name: _____ EE first name: _____ EE SS # last 4 digits: _____

Patient (PA) last name: _____ PA first name: _____ PA SS # last 4 digits: _____

Mailing address: _____ City: _____ State _____ Zip code: _____

Please check type of claim: ____ (HRA) ____ (FSA) ____ (dependent care) ____ (HSA)

Please specify one of the following by initialing after the appropriate statement:

I have included a copy of a voided check, so that I may receive my reimbursement electronically (EFT). _____

I wish for my reimbursement to be delivered by the US Postal Service. I understand that my reimbursement will be reduced by $7.00 to cover postage, printing, and handling. _____

_____ _____

employee signature date submitted

FOR HOME OFFICE USE ONLY: ID #: _____ $ processed _____ $ paid_____

Notes_____

_____ processor_____