AMERICAN BENEFITS GROUP

RE-PAYMENT FOR INELIGIBLE REIMBURSEMENT

Your Name: _____ Last 4 digits of SS#: _____

Employer: _____ Email: _____

Information on original claim or transaction:

Name of the provider:_____Transaction Date: _____

Amount of reimbursement or myFlexResource Benefits Card transaction: $ _____

Please check the reason for re-payment:

☐ My claim was reimbursed out of the incorrect benefit account

Check the box for the benefit account the claim was paid out of:

☐ FSA ☐ Dependent Care ☐ HRA ☐ Parking ☐ Transit

Check box for benefit account the transaction should have paid out of:

☐ FSA ☐ Dependent Care ☐ HRA ☐ Parking ☐ Transit

☐ I used my ABG Benefits Card to pay for an expense that was determined to be ineligible or I received a reimbursement from American Benefits Group for an expense that was later determined to be one of the following: Ineligible, an overpayment, a duplicate reimbursement, or covered by other insurance.

☐ I have enclosed a check payable to American Benefits Group to repay this reimbursement.

☐ To offset this ineligible expense, I am submitting substantiation for eligible expenses from a provider showing: patient name, date of service, type of item or service and amount, for an HRA expense you must submit an Explanation of Benefits (EOB). Your eligible expense must equal or exceed the total of your ineligible expense or your card privileges will continue to be suspended until the debt is paid in full. (please fill in form below)

Date Incurred	Name of Service Provider	Expense Description	Person for Whom Expense was incurred	Amount
			TOTAL	

Upon receipt these repayments will be processed against your benefit account and your account balance will be adjusted.

The undersigned participant in the Plan, certifies that all expenses being submitted for reimbursement on this claim form, were incurred during a period when the undersigned was covered under the Company's HRA Plan. In addition the undersigned certifies that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for repayment of all such expenses.

Employee's Signature: _____ Date:_____

Please submit this form along with substantiating statements or EOBs.
Fax Toll Free: 877-723-0147 or email to claims@amben.com
No Fax Machine? Mail to: American Benefits Group
PO Box 1209, Northampton, MA 01061-1209 • 800-499-3539