PRIMEPAY®

Reset Form | Email Form

Office Use Only	
Date Processed:	/ /
Processed by:	Client #:

PrimeFlex—(877) 769-3539

Provider Pay Form

Please complete this form and submit it to PrimeFlex.

Employee Information (Please print clearly) ☐ **PLEASE CHECK HERE IF THIS IS AN ADDRESS CHANGE**

Name: (Last, First, Middle)		SSN:	Date of birth:
Street:	City:	State:	Zip:
Employer:			Work #:
Email:			Home #:

Please provide us with the following information so that we may pay medical providers directly. ALL INFORMATION IS REQUIRED.

Medical Provider #1

Medical Provider Name: (Make check payable to)			
Provider Address: Street	City	State	Zip
Patient Account Number:			

Medical Provider #2

Medical Provider Name: (Make check payable to)			
Provider Address: Street	City	State	Zip
Patient Account Number:			

Medical Provider #3

Medical Provider Name: (Make check payable to)			
Provider Address: Street	City	State	Zip
Patient Account Number:			

Send this form to PrimeFlex, in one of the following ways:

	For HRA Participants		For All Others
Fax	877.6FAX.HRA	Fax	877.6FAX.FSA
Email	primeflexHRA@primepay.com	Email	primeflex@primepay.com
Mail	Attn: PrimeFlex-HRA 1487 Dunwoody Drive West Chester, PA 19380	Mail	Attn: PrimeFlex-FSA 1487 Dunwoody Drive West Chester, PA 19380

I hereby authorize PrimeFlex and its affiliates (hereinafter COMPANY) to send any amounts owed me to the medical providers (hereinafter PROVIDERS) indicated above. Further, I authorize PROVIDERS to accept and to credit any such entries indicated by COMPANY to my account. In the event that COMPANY sends funds erroneously to PROVIDERS, I understand that I must collect payment for an amount not to exceed the original amount of the erroneous credit and submit it to COMPANY. I understand I am responsible for confirming my payment has been properly sent to PROVIDERS. Any resulting charges that occur because I have failed to abide by this will be my responsibility.

Employee Signature: _____ **Date:** ____/____/____