

Office Use Only			
Date Processed:	/	/	
Processed by:	Clien	nt #:	

PrimeFlex—(877) 769-3539

Claim Reimbursement Form

Please complete this form and submit it along with all forms of documentation which may include EOB, receipts, and/or proof of payment to PrimeFle
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*Please consult your plan documents for a list of eligible expenses. Total *Please consult your plan documents for a list of eligible expenses. Total *Yes, please issue payment directly to the medical provider(s) of service. I confirm that I have completed the provider pay information below included the MEDICAL INVOICE for each provider requiring direct payment from PrimeFlex. All INFORMATION IS REQUIRED. Medical Provider Name: (Make check payable to) Provider Address: Street City State Zip Patient Account Number:	Name: (Last, First, Middle)			SSN:		Date of Bir	th:
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