PEAK1 ADMINISTRATION

Insert Group Name
Fax cover sheet
Fax to: 1-855-495-3669
www.MyPeak1.com

Please fill in completely:

Employee Name	Date	
Email	Phone	
Street Address		
City	State	Zip

Dependent Information is required for claims to be processed		
Dependent Name	**Date of Birth**	**Social Security Number**

Please complete the following:

1. Check the benefit program you would like your claim reimbursed under:

☐ **Health Reimbursement Account (HRA)** only.

☐ **Flex Spending Account (FSA)** only - Please include FSA Claim Form.

☐Unreimbursed Medical

☐Unreimbursed Dependent Care

☐Used Peak1 Debit Card

****PLEASE INCLUDE AN ITEMIZED PROVIDER STATEMENT OR EXPLANATION OF BENEFITS (EOB)***

☐ **Health Reimbursement Account <u>and</u> Flex Spending Account***

2. Submit insurance company Explanation of Benefits and/or provider (doctor, hospital, drug store, etc.) receipts of payment or similar documentation with this form.

Upon receipt of the above, your claim will be processed within 3-5 business days. If you have questions regarding reimbursement processing, please contact MemberCare at 866-315-1777 or email us at membercare@mypeak1.com.

* By choosing this option, I understand that all charges not eligible for reimbursement under the HRA but eligible under my FSA plan will be reimbursed from my FSA account. To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction. I will be reimbursed according to the total amount of eligible expenses on the attached receipts.

Employee Signature Verification X _____ **Date** _____

required to process reimbursement