An Aetna Company
PAYFLEX®

Health Care FSA & Dependent Care FSA Claim Form

Mail or Fax completed form and documentation to:
PayFlex Systems USA, Inc.
PO Box 14879
Lexington, KY 40512-4879
Phone: 1-866-201-0627
Fax: 1-859-381-5680
For the hearing impaired, call 1-877-703-5572

To help avoid claim processing delays, you must sign, date and complete this form. You must also include supporting documentation.
WAIT! Did you know that you can file a claim online or by using the PayFlex Mobile® app? To get started, log in to the mobile app or your member website which is accessible via www.aetna.com. You can also find instructions online for completing this form.

Employee's Aetna Identification Number *(Can be found on an Aetna Medical ID card/ Aetna EOB or by calling customer service)*	**Member Full Name** *(Last Name, First, MI)*
Member Address *(Street, City, State, ZIP Code)*	

Note: If you have an address change, please notify your employer. For security purposes, we can only accept an address change from your employer.

Employer Name
Johnson & Johnson Family of Companies

Health Care FSA Expenses (For you, your spouse/partner and your eligible dependents)

Patient Name	**Type of Service** (deductible, dental, medical, orthodontia, over the counter, pharmacy, vision)	**From Date of Service** (not payment date) MM/DD/YYYY	**To/Thru Date of Service** (not payment date) MM/DD/YYYY	**Amount Requested**
				$
				$
				$
				$
				$
			Total	$

****If more lines are needed, please complete another form You can get a claim form by logging onto http://digital.alight.com/jnjbsc. Claims forms can also accessed by visiting and logging onto www.aetna.com.**

Dependent Care FSA Expenses (Child or Adult)

If your caregiver completes and signs below, you do not need to include an itemized statement.**If requesting for multiple dependents, each dependent must be listed on a separate line.**

Exact Dates of Service					
From MM/DD/YYYY	**To** MM/DD/YYYY	**Amount Requested**	**Qualifying Person's (Dependent's) First and Last Name** (Please Print)	**Age** On Service Date	If qualifying person (Dependent) is under age 13 OR is mentally or physically incapable of self-care due to a diagnosed medical condition and is over age 12. ***Please check, if Yes.**
		$			☐ Yes
		$			☐ Yes
		$			☐ Yes
		$			☐ Yes
	Total	$	***You do not need to submit evidence of diagnosed medical condition.**		

Caregiver Information/Certification
My signature certifies that I have provided the services for these expenses for
____
(Qualifying Person's (Dependent's) First Name)
Name *(Must be printed)* ____________________
Relative: ☐ Yes ☐ No
Provider Signature ____________________

Caregiver Information/Certification
(**Note:** This is for a second caregiver, if you have more than one.)
My signature certifies that I have provided the services for these expenses for
____
(Qualifying Person's (Dependent's) First Name)
Name *(Must be printed)* ____________________
Relative: ☐ Yes ☐ No
Provider Signature ____________________

For Health Care FSA Flexible Spending Account: I certify the expenses for which I am seeking reimbursement from Health Care FSA have been incurred by me, or by an individual who qualifies as my spouse or my dependent for health coverage purposes under Federal tax law (refer to the Health Care FSA Plan Details for a definition of whose expense are covered) per IRS guidelines. I further certify that these expenses have not been reimbursed, nor shall reimbursements (or further reimbursements) be sought, from any other health plan coverage, whether or not maintained by Johnson & Johnson, including a Health Reimbursement Arrangement (HRA) or Health Savings Account (HSA). I also certify that I have not, and will not, claim a tax deduction or credit for these expenses on my federal income tax return, or on my state or local tax returns in violation of state or local law. I agree to submit sufficient documentation for any expenses for which I seek reimbursement and retain copies for my records. They are not for cosmetic reasons. I understand that "incurred" means the service has been provided.

For Dependent Care FSA Flexible Spending Account: I certify that I have incurred all expenses listed above for which I am seeking reimbursement from the Dependent Care FSA. I further certify that these expenses have not been reimbursed, nor shall I seek reimbursement from any other dependent care assistance program. I also certify that I have not, and will not, claim a tax deduction or credit for these expenses on my federal income tax return, nor will I claim a tax deduction or credit for these expenses on my state or local tax returns in violation of state or local law. I further certify that the above dependent care expenses are for the care of a qualifying person (refer to the Dependent Care FSA Plan Details for the definition of "qualifying person") and do not include separate charges for food, clothing, education, entertainment, activities, late fees or overnight care. I agree to submit sufficient documentation for any expenses for which I seek reimbursement and retain copies for my records.

Please note: Any person who knowingly, and with intent to defraud, files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime. Your coverage under Health Care FSA/and or Dependent Care FSA may be terminated (including retroactively) and funds remaining in your account may be subject to forfeiture.

Member Signature	**Date**
✍	

If you are mailing your claim, please keep a copy of this claim form and supporting documentation. We will not return these documents.