



Approved Product Purchase – Reimbursement Form

If you have purchased an approved product and would like to request reimbursement based on your plan allowance, complete this form and include a copy of your receipt. Once verified, funds will be deducted from your card balance, and a check will be mailed within 7–14 business days.

To submit a reimbursement request, mail a completed copy of this form along with a copy of your itemized receipt to the address below. You may also email the completed form and an image of your itemized receipt to **HMSAclaims@FlexCardService.com**.

HMSA Reimbursement Request
27200 Tourney Road, Suite 450
Valencia, CA 91355

First Name: _____ Last Name: _____

Mailing Address (on file): _____
(Street, City, State, Zip)

Medical Member ID: _____
(Do not use your debit card number.)

Date of Birth: ____/____/____

Member Phone #: _____ Plan Name: _____

Member Email Address (optional): _____

Date of Purchase/Service: ____/____/____ Amount Paid Out-of-Pocket: \$_____

Item Category: _____
(OTC, Groceries, Fitness, Utility, etc.)

Retail Location/Service Provider: _____

Additional Notes: _____

Please attach a copy of your itemized receipt.
Reimbursement requests cannot be processed without it.