

Sample Claims Filing Process Screenshots from ASIFlex's Online Self Service Center

<https://my.asiflex.com>

Please note: You must use the Pin number assigned to you by ASIFlex. To obtain yours, contact ASIFlex at: 800-659-3035. Instructions are available on the CSU Benefits Portal: www.calstate.edu/hr/benefitsportal.

Step 1 & 2:

Welcome to ASIFlex's Online Self Service Center

To begin, please enter your PIN:

If you don't have a PIN, please contact us at (800) 659-3035.

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Step 3:

Welcome to ASIFlex's Online Self Service Center

[Log Out of MyASIFlex.com](#)

Fax Status

[No digital images \(faxed or uploaded\) associated with your PIN are in queue.](#)

Section 125 Account Detail

Plan Year: Account Detail:


More Participant Service Options (requires additional authentication)

[File a reimbursement claim online](#)

[Secure Message Center](#)

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Step 4:



Welcome to ASIFlex's Online Self Service Center

[Log Out of MyASIFlex.com](#)


Additional Authentication Required

You have selected a feature which, for your protection and privacy, requires additional authentication.

Please enter your Social Security Number (SSN):

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Step 5:



Welcome to ASIFlex's Online Self Service Center

[Return to MyASIFlex.com](#) [Log Out of MyASIFlex.com](#)

Before You File a Claim Online

At the present time, only **Health Care** and **Dependent Care** claims can be filed online. Parking, Mass Transit and Van Pool claims cannot be filed online. If you are not filing a **Health Care** or **Dependent Care** claim, please answer "NO" below to return to the main menu.

FIREFOX USERS PLEASE NOTE: The upload component has been known to generate errors with some previous versions of Firefox. Some versions of Firefox may not correctly validate your PDF uploads. This application is best suited to run on Internet Explorer.

In order to file a claim online, you **must** have your supporting documentation scanned and saved in **PDF format**, ready to upload.

You have twenty (20) minutes to complete the claim, or the system will time out. For this reason, you should have your supporting documentation scanned into a PDF file **before you begin this process**.

Because of the many and varied programs, applications and methods of creating a PDF file, we are unable to assist you with creating your PDF file(s). If you are not comfortably able to generate a PDF file or upload files via the web, please **stop now**, and [submit a claim by Fax or by Mail](#).

Have you already scanned your supporting documents into PDF?

Yes
 No

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Step 6:

Welcome to ASIFlex's Online Self Service Center

[Return to MyASIFlex.com](#) [Log Out of MyASIFlex.com](#)

File a Claim

Only plan years for which you can submit claims today appear below:

Begin a new Health Care or Dependent Care claim for plan year

(Note: From this point forward, please **DO NOT use your browser's BACK button.** Doing so may produce unpredictable results and prevent your claim from being received and/or correctly processed.)

[Return to MyASIFlex.com](#) [Log Out of MyASIFlex.com](#)

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Step 7:

Welcome to ASIFlex's Online Self Service Center

Please indicate the type of claim you would like to file:

Health Care Reimbursement Account
 Dependent Care Assistance Account

If you have more than one type of claim, please choose one now, and then file a separate claim for the other type(s) that you have. Online claims are limited to one type per claim.

If no choices appear above, you cannot file any claims online, either because you have not elected to participate or because you have exhausted your reimbursement claims limits. If you believe this to be an error, please contact ASIFlex customer service at (800) 659-3035 or (573) 442-3035.


Remember: **DO NOT** use your browser's BACK button, as this may prevent your claim from being received or properly processed.

[Return to menu without filing a claim](#)

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Step 8:

Welcome to ASIFlex's Online Self Service Center



Remember: **DO NOT** use your browser's BACK button, as this can prevent the receipt and/or correct processing of your claim. Use one of the navigation links at the bottom of the page if necessary.

First date of service (MM/DD/YYYY)	Last date of service* (MM/DD/YYYY)	Name of Medical Provider	General Medical Expense Description
01/15/2011		CVS/Pharmacy	Pharmacy Co-pay

Name of person for whom expense was incurred	Relationship of this person to you	Amount
John Doe	Self	5.00

* If there was only one date of service, leave this box blank.

Add to Claim

Health Care Reimbursement Account Claim

There are no entries on this claim form yet.

Claim Total: **\$0.00**


File Claim

[Delete this claim without filing](#)

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Step 9:

Welcome to ASIFlex's Online Self Service Center



Supporting Documentation

Attachment #	Attachment File Name
1	Pharmacy Claim.pdf

Please upload your supporting documentation (PDFs only, **maximum file size 4MB**). If you have more than one PDF document, please upload them in the order you'd like us to see them (usually in the order in which you listed them on your claim form).

Select the PDF file you wish to upload here: **Browse...**

After you've selected the file you want to send us above, click here to upload it. **Upload**


(Please be patient...this screen will not change until the file is completely uploaded. Depending on bandwidth available and the size of your file, it could take up to ten minutes.)

When you've finished uploading all the files you want to send, you can [print this page](#) for your records, and then you should click the **Continue** button to proceed.

Continue

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Step 10:



Welcome to ASIFlex's Online Self Service Center

File Your Claim


I hereby certify that I am a participant in the plan and that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while I was covered under my employer's Flexible Spending Plan with respect to such expenses and that the expenses have not been reimbursed and are not reimbursable from any other source. I fully understand that I alone am fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by me, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state or local income tax on amounts paid from the Plan which relate to such expense.

Indicate your acceptance of the above terms by typing your first and last name on the line below. This is the legal electronic equivalent of your signature.

Signature (type your name here):

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Step 11:



Welcome to ASIFlex's Online Self Service Center

Claim Submitted

Your Claim ID is **2011-28886**

[Return to MyASIFlex.com](#)

If you require assistance with this claim, please contact ASIFlex as (800) 659-3035.

Please note, it can take up to 20 minutes from the time you receive your claim number until our Customer Service Representatives are able to see that you have submitted this claim. Claims are processed in the order they are received. Please be mindful of this when making inquiries concerning your claim.

[Print this page](#)

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