



**FLEX VAL REQUEST FORM**

**Department Name and UH Department Number:** \_\_\_\_\_

**Department Building Address:** \_\_\_\_\_

**Billing Address (if different than Department Address):** \_\_\_\_\_

**Approval Signature:** \_\_\_\_\_

**(Director or Equivalent Approval Signature Required for All New FlexVal Accounts)**

**Department Contact**

**Name:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**PSID#:** \_\_\_\_\_

**FLEXVAL Account Balance Request and Department Billing Info**

**Existing FlexVal Users – FlexVal Provider Name:** \_\_\_\_\_

**Amount to be Added to Account Balance:** \_\_\_\_\_

**Cost Center:** \_\_\_\_\_

**Account Code:** \_\_\_\_\_

**Certifying Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_