## Patient Information



## Prescriptions

Use one line per prescription expense, and attach a prescription receipt.

| Date of Fill | National Drug Code number \& Name of Prescription | Amount Paid |
| :--- | :---: | :---: |
|  |  |  |
|  |  | Total Paid | \$ 0

## Employee Certification

By signing below I certify that:
$>$ The above information is correct, and I am responsible for the accuracy of all information relating to this claim;
$>$ I have not previously received reimbursement for these expenses;
$>$ Expenses were spent by me, my spouse, or eligible dependents and
$>$ My reimbursed Health care expenses cannot be used as a deduction on my personal income tax return.

## Employee Signature

## Form Submission

Email to: Service@Healthez.com Fax to: 952-896-4888 Mail to: HealthEZ, Claims, 7201 W 78th St Bloomington, MN 55439
For further assistance, call the number on the back of your medical card.

