Medical Care & Prescription Expense Claim Form

Copy your form and receipts for your own records.



Patient Information

Last Name	First Name	Date of Birth
Member ID or Social Security Number		

Email Address	
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Phone Number

Medical Care

Use one line per medical expense, and attach a copy of your medical claim(s).

Date(s) Service was incurred		HCPC/Diagnosis Code/CPT Code	Amount Paid
From	Through		
Total Paid		\$	
Name of Medical Facility Medical Facility Address		Medical Facility Address	•
Name of Prov	ame of Provider Tax ID		

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	\$
Name of Pharmacy		Pharmacy Address	

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

Date

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.