Medical Care & Prescription Expense Claim Form

Copy your form and receipts for your own records.

HEALTHEZ

Patient Information

Last Name	First Name	Date of Birth
Member ID or Social Security Number		
Email Address	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	$ 0
Name of Medical Facility		**Medical Facility Address**	
Name 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	$ 0
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.

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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.