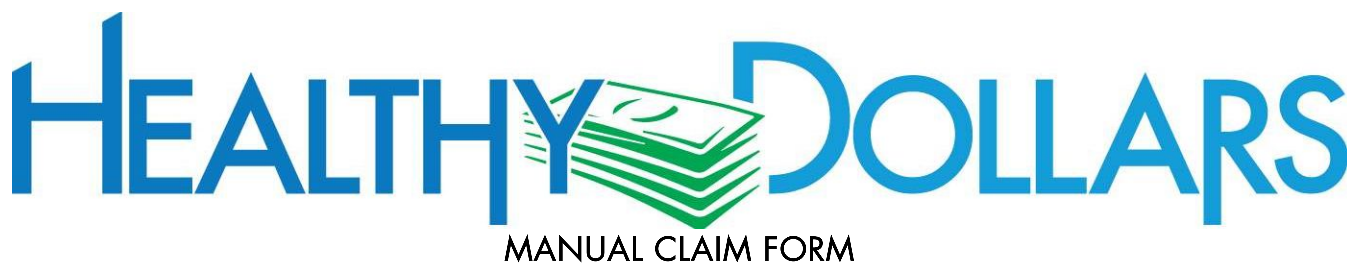

MANUAL CLAIM FORM

Participant Name: ___________________________ Employer Name: ________________________________

Street Address: __________________________ City, State, Zip: ________________________ ☐ Check here if address change

Date(s) of Service	Name of provider and or pharmacy	Patient Name	Amount requested for reimbursement	Would you like Healthy Dollars to send a check directly to the provider for you? **If Yes, include Provider Bill** YES*	NO

TOTAL AMOUNT REQUESTED FOR REIMBURSEMENT **$**

Please include the proper documentation for your claim as detailed below*:

For Medical Services:

- ☐ An Explanation of Benefits from my Health Insurance Company OR a detailed statement from my provider showing date of service, procedure and insurance processing.

For Pharmacy Services:

- ☐ A copy of the prescription receipt from the pharmacy, a print out from my pharmacist or a detailed register receipt
- ☐ A copy of the detailed register receipt showing OTC medication and a copy of the doctors prescription

For Dental or Vision Services:

- ☐ Detailed statement from provider showing date of service and procedure

*Credit card receipts are not valid forms of documentation

Reimbursement: If we are reimbursing you directly (not the provider) please complete the following bank information so we may direct deposit the funds into your account.

Direct Deposit Information		
Bank Name:		
Account Number:	Checking	Savings
Routing Number:		

I certify that these expenses have been incurred by me, my spouse or my eligible dependent. The expenses have not been reimbursed and are not reimbursable under any other plan, such as an individual policy or my spouse's or dependent's plan. I understand that any amount reimbursed may not be used to claim any federal income tax deduction or credit on my or my spouse's income tax return. I further certify that dependent care expenses were incurred for the purpose of allowing me (and my spouse, if applicable) to be gainfully employed.

Participant's Signature: ______________________________________ Date: ___________________

Please send completed forms and documentation to:
Email : Service@healthydollarsinc.com, Fax: 877-687-6921
For Questions, please call 877-900-MYRX (6979).