Medical Expense Claim Form

Retain a copy of this form and receipts for your own records.

Patient Information

Last Name	First Name	Date of Birth
Subscriber ID		
Email Address	Phone Number	

Medical Expenses

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

Date(s) of Service		HCPC/Diagnosis Code/CPT Code	Amount Paid
From	Through		
1	1		
1	1		
1	1		
		Total Paid	$

Name of Medical Facility	**Medical Facility Address**
Name of Provider	**Tax ID**

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 these expenses;
- I have not previously received reimbursement for these expenses;
- Expenses were incurred by me or eligible dependents, and
- My reimbursed health care expenses will not be used as a deduction on my personal income tax return.

Employee Signature **Date**

Form Submission

Email to: claimsubmission@healthez.com

Fax to: 952-896-4888

Mail to: HealthEZ, ATTN: Claims, 7201 West 78th Street, Bloomington, MN 55439

For further assistance, call the number on the back of your insurance card.