MANUAL CLAIM FORM

PARTICIPANT NAME: ______________________ **EMPLOYER NAME:** ______________________

O **Check here if address has changed:**

STREET ADDRESS: ______________________ **CITY, STATE & ZIP:** ______________________

E-MAIL ADDRESS: ______________________ **PHONE NUMBER:** ______________________

Would you like Healthy Dollars to pay your provider directly? O **No** O **Yes** (Please include Provider bill.)

Service Date	Provider Name	Patient Name	Monetary Amount
		TOTAL AMOUNT REQUESTED TO BE PAID OR REIMBURSED:	$

*Please include the proper documentation for your claim as detailed below:
*Credit card receipts are not valid forms of documentation.

For Medical Services:

O An Explanation of Benefits from my Health Insurance Company OR an Itemized Invoice from my provider showing date of service, procedure and insurance processing.

For Pharmacy Services:

O A copy of the prescription receipt from the pharmacy, a print-out from my pharmacist or a detailed register receipt.

O A copy of the detailed register receipt showing OTC medication and a copy of the doctor's prescription.

For Dental or Vision Services:

O Itemized Invoice from provider showing date of service and procedure.

DIRECT DEPOSIT INFORMATION: O **Check here if Banking Information has changed**

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.

BANK NAME:	O **CHECKING** O **SAVINGS**
ROUTING NUMBER:	
ACCOUNT 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 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).