HEALTH REIMBURSEMENT CLAIM FORM

Employer | My Phone #

Name | SSN

Address

City | State MN | Zip Code

Please submit documentation that gives the following information:
1. Name of Provider or Clinic
2. Name of Person Receiving Service
3. Type of Eligible Expense
4. Date Service was Rendered (not paid)
5. Total Expenses Incurred
6. Evidence that payment has been made by the claimant

FOR MEDICAL AND DENTAL REIMBURSEMENT AN EXPLANATION OF BENEFITS (EOB) FROM YOUR HEALTH OR DENTAL INSURANCE WILL SATISFY THE ABOVE REQUIREMENTS.

- Fill in the lines below, sign your name and attach all required documentation.
- Keep a copy for your records and mail the original with documentation to:

Formula Corporation
HRA Claims
2919 Eagandale Blvd., Suite 120
Eagan MN 55121-1464
OR Fax to: 651-686-0513

If you have any questions please call: 651-686-0108;
or toll free 1-888-686-0412

Name of Provider (Doctor, Dentist, Etc.)	Person Receiving Service	Type of Expense	Date Expense was Incurred	Total Expenses	Amount Paid By You

TOTALS

I hereby certify that the information above is true and correct, and that neither I, my spouse, nor any of my eligible dependents have or will receive reimbursement for any of the expenses listed above from any other source, and furthermore, that I have not, and will not, claim any of these expenses as a deduction on, or in calculating a credit from my/my spouse's income taxes. In addition, I certify that the "Person Receiving Services" listed above is eligible to be covered under the Plan.

Current Date

Participant Signature (*spouse or dependent signatures will not be accepted*)

Print Form