MANUAL CLAIM FORM

Participant Name: ___________________________ Employer Name: ________________________________

Street Address: ______________________________ City, State, Zip: __________________________________

☐ Check here if name/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

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the employer's HRA or FSA Plan with respect to such expenses and that the expenses have not been reimbursed and are not reimbursable from any other source. Any Dependent Care Assistance expenses claimed here were provided for my dependent under the age of 13 or for a dependent that is incapable of self-care. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense. All payment of claims is from the employer's general assets.

Participant's Signature: __________________________ Date: ____________________

Please send completed forms and documentation to:
Email : Service@healthydollarsinc.com
Fax: 877-687-6921
Mail: Healthy Dollars Claims Administration PO BOX 8592, ESSEX, VT 05451
For Questions, please call 877-900-MYRX (6979).