CONSOCIATE HEALTH | GETMOR

Claims Reimbursement Form

Employee Name	Social Security or ID #	Employee Phone Number	
Employee Mailing Address (P.O. Box or St. Address)	City	State	Zipcode
Company/Employer Name	Employee Email		

Date of Service List each date of service separately	**Claim Amount**	**Medical Condition ***	**Complete Description of Eligible Expense** Do not use abbreviated description from the receipt.	**Provider of Service / Merchant**
Total				

Participant Signature _____ Date _____

Your signature is required for reimbursement.
Failure to sign or complete this form in its entirety will delay processing. Incomplete forms will be returned.

Email, fax or mail this completed form to **GetMOR@Consociate.com**

Claims Reimbursement Form

Acceptable Receipt


CVS/pharmacy

I'm BRANDY M., I'm here to serve you with our '7 Service Basics'

445 10 4188 05706 027

RRN# 0570-8274-1889-0401-1620

HALL C/D 495 1 1.00 SALE
ADVIL TAB 85 1 1.99
HANK YOU&ME 1A 2.49
SUBTOTAL 5.48

A=8.25% SALES TAX .21
TOTAL 5.69

CASH 20.00
CHANGE 14.31

18090 EL CAMINO REAL HOUSTON, TX

OPEN 24 HOURS
THANK YOU
FOR FASTER SERVICE, CALL IN YOUR PRESCRIPTION ORDER

JANUARY 16, 2004 12:07 PM

This receipt's line items are descriptive and show which SPECIFIC items were purchased.

Unacceptable Receipt


1730 BLAIRSFERRY RD
HIAWATHA, IA 52233
319-393-4644

Merchant ID: 1000 Ref #: 6002

Sale

MAST Entry Method: Swiped

Total: $ 5.90

07/13/10 05:20:30
Inv #: 000002 Appr Code: 052030
Approvd: Online Batch#: 000041

Customer Copy

THANK YOU!

This receipt does not provide any detailed information on what was purchased.

By returning this form, I, unless otherwise noted, certify that:

1. All claims listed are to be deducted from my FSA balance first (if applicable) since those $'s are forfeited if not used by year end.
2. The health care related eligible expenses submitted with this form have not been reimbursed by any insurance carrier or employer sponsored health or dental care plan.
3. The expenses claimed above have not been, and will not be, taken as a credit or deduction on my personal income tax return.
4. The expense above was for myself or an eligible Dependent as allowed under the Plan.

*** A description of the *Medical Condition*** being addressed/alleviated is required. Please note that **expenses for "general health" are NOT eligible**. However, for example, vitamins/minerals for the prevention of obesity, heart disease, etc. are an eligible expense since they are for the prevention of a specific medical condition/disease.

Supporting Documentation Needed – You must attach a receipt/statement of expense showing the type of service, the date of service and the amount of expense. For example, an Explanation of Benefits (EOB), an itemized physician bill, itemized receipt or some other sort of third party substantiation. Credit card signature slips and balance forward statements are not acceptable.

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