

EMPLOYER AND EMPLOYEE INFORMATION

## CLAIM FORM PREFUNDED HEALTH SPENDING ACCOUNT

**TOTAL** 

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Employer Name	·				
Employee Name	e			Date of Birth (M/D/Y)	
	First Name	Initial	Last Name		
Address				Telephone: Res.	
City or Town $\_$				Telephone: Cell	
Province	e Postal Code			Email Address	
CLAIM INFO	DRMATION				
including receip returned). Cash, For Practitioner or Pa name, practitioner n	ts; or 3) regular mail v debit or credit card rec aramedical expenses (eg., chiro	vith original eipts, or can opractor, massag istration number	receipts included celled cheques ge therapist, physic, date of service, a	ectronic copies of receipts included; and (please retain copies as original are not acceptable as a substitute otherapist) please attach an itemized statement charge for treatment. For equipment and statements.	al receipts will not be for a proper receipt. ent or receipt stating patient
Date (M/D/Y)	Patient Name		Descript	ion of Item or Expense	Amount
2 3.22 (3.427.17					

Email claims@medidirect.ca, fax or mail to MediDirect® Inc. - P.O. Box 1710, Station M, Calgary, AB T2P 2L7
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