"Tab" Between Fields to Complete

GetMOR Claims Reimbursement Form

Employee Name | **Social Security or ID #** | **Company/Employer Name** | **Employee Email**

Employee Phone Number | **Employee Mailing Address** (P.O. Box or Street Address) | **City** | **State** | **Zipcode**

Date of Service List each date of service seperately	**Claim Amount**	**Medical Condition***	**Complete Description of Eligible Expense** Do not use abbreviated description from the receipt.	**Provider of Service / Merchant**
SAMPLE 2/17/2010	*$34.95*	*Anemia*	*SAMPLE: iron tablets, toothpaste*	*CVS*
Total	$			

☐ If the claim amount is greater than my FSA and/or HRA account balance, please pay me the remainder of this claim from my **VEBA** investment funds, if applicable.

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.

* **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.

Acceptable Receipt

CVS/pharmacy

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

445 10 4188 05709 027

RFN# 0570-8274-1889-0401-1620

HALL C/D 40S 1 1.00 SALE
ADVIL TAB 8S 1 1.99
H/MK YOU&ME 1A 2.49
SUBTOTAL 5.48

A=8.25% SALES TAX .21
TOTAL 5.69

CASH 20.00
CHANGE 14.31

18590 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

BLAIRSFERRY FAMILY PHARM
1798 BLAIRSFERRY RD
HIAWATHA, IA 52233
319-393-4544

Merchant ID: 1898

Ref #: 0002

Sale

MAST Entry Method: Swiped

Total: $ 5.98

07/19/10 06:20:38

Inv #: 000002 Appr Code: 052030

Apprvd: Online Batch#: 000341

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.

Email, fax or mail this completed form to CustomerService@theGetMORplan.com
GetMOR ▪ 958 Mezzanine Dr., # B ▪ Lafayette, IN 47905 ▪ (888) 900-4MOR ▪ (765) 446-1701 Fax