"Tab" Between Fields to Complete

GETMOR "Pending" Expense Verification Form

To be used for unsubstantiated transactions. Incomplete forms will be returned.

Employee Name | **Social Security or ID #** | **Employee Phone Number**

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

Company/Employer Name | **Employee Email**

☐ **The enclosed documentation is to be used to OFFSET unsubstantiated or ineligible transactions for which I cannot provide receipts.**

Date of Service	"Pending" Amount	Medical Condition *	Complete Description of Eligible Expense Do not use abbreviated description from the receipt.
SAMPLE 2/17/10	*$37.95*	*Osteoperosis*	*SAMPLE: prescriptions, calcium, bandages*

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 BS 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

Unacceptable Receipt

BLAIRSFERRY FAMILY PHARMA
1750 BLAIRSFERRY RD
HIAWATHA, IA 52233
319-393-4944

Merchant ID: 1000 Ref #: 0002

Sale

MAST Entry Method: Swiped

Total: $ 5.90

07/13/10 05:20:30
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.

*** 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.

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