INTERACTIVE FORM - CLICK ON FIRST LINE TO BEGIN. USERS OF READER 7 AND LATER CAN SAVE DATA TYPED INTO THIS FORM

PRINT BLANK CLAIM FORM | CALCULATE AMOUNTS AND PRINT FORM | RESET FORM (CLEAR ALL FIELDS)

MediDirect®
Your Health, Dental & Wellness Benefit Plan

CLAIM FORM
PREFUNDED HEALTH SPENDING ACCOUNT

EMPLOYER AND EMPLOYEE INFORMATION

Employer Name _____

Employee Name _____ Date of Birth (M/D/Y) _____
First Name Initial Last Name

Address _____ Telephone: Res. _____

City or Town _____ Telephone: Cell. _____

Province _____ Postal Code _____ Email Address _____

CLAIM INFORMATION

Claims must be accompanied by original receipts. Cash, debit or credit card receipts, or cancelled cheques are not acceptable as a substitute for a proper receipt. Please retain copies as original receipts will not be returned.

For Practitioner or Paramedical expenses (eg., chiropractor, massage therapist, physiotherapist) please attach an itemized statement or receipt stating patient name, practitioner name, type, licence and/or registration number, date of service, and charge for treatment. For equipment and appliance expenses, please attach a written recommendation from the prescribing physician, including diagnosis.

Date (M/D/Y)	Patient Name	Description of Item or Expense	Amount
		TOTAL	

Attach original receipts to form and send to MediDirect® Inc. - P.O. Box 1710, Station M, Calgary, AB T2P 2L7
Phone: (403) 537-6298 • Toll Free (866) 234-5162 • Fax (403) 539-5511 • www.medidirect.ca

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CALCULATE AMOUNTS AND PRINT FORM