



# Health Care Benny Card Receipt Claim Form

**PERSONAL INFORMATION:**Last Name:  First Name: ID Number:  Phone Number: Name of Employer: **REIMBURSEMENT INFORMATION:**

	Service Dates:		Provider Name:	Type of Service*:	Card Amount:
	From:	To:			
1.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
7.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
8.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
9.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
10.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>TOTAL:</b>					<input type="text"/>

Attach **COPY** of itemized receipts.

Documentation submitted to substantiate Benny Card transactions must include:

- Date of Service
- Type of Service provided
- Amount of expense incurred
- Provider Information

When listing the Type of Service on the claim form, be specific. Examples include copay, glasses, orthodontics, mileage, and over-the-counter item names.

Dual-purpose claims must include documentation showing the medical practitioner's diagnosis and treatment recommendation.

I certify that the expenses for which I am requesting reimbursement meet all the conditions listed below:

- They were incurred for services or supplies received by my eligible dependents or me under the plan.
- They were for services or supplies furnished on or after the effective date of my employee reimbursement account.
- I have not been reimbursed for these expenses in any other way or from any other source.

**EMPLOYEE SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_**FAX TO:** 877-390-4782 (toll-free) or 715-841-7049**SEND TO:** UMR • MS 6354, Claim Services • P.O. Box 8022 • Wausau, WI • 54402-8022**INQUIRIES:** www.UMR.com • 1-800-826-9781*The deadline for filing current year claims for reimbursement is 90 days after the end of the plan year unless otherwise specified in your Plan Document.*