Health Care
Benny Card Receipt Claim Form

PERSONAL INFORMATION:

Last Name: ____________ First Name: ____________

ID Number: ____________ Phone Number: ____________

Name of Employer: ____________

REIMBURSEMENT INFORMATION:

	Service Dates: From:	To:	Provider Name:	Type of Service*:	Card Amount:
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
				TOTAL:	

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.

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