Medical Expense Claim Form Miora Minnesota

Patient Information

Last Name	First Name	Date of Birth
Subscriber ID		
Email Address	Phone Number	

Medical Expenses

Use one line per medical expense and attach Miora invoice and paid receipt

Date(s) of Service		Services	Amount Paid
From	Through		
		Draw Fee	
		Metabolic Code Profile	
		Total Paid	$

Name of Medical Facility MIORA MN, P.C. dba MIORA	**Medical Facility Address** 600 1ST Avenue North Minneapolis, MN. 55403
Name of Provider Gregory Pippert	**Tax ID** 99-2867079

Certification By signing below I certify that:

- The above information is correct, and I am responsible for the accuracy of all information relating to these expenses;
- I have not previously received reimbursement for these expenses;
- Expenses were incurred by me or eligible dependents, and
- My reimbursed health care expenses will not be used as a deduction on my personal income tax return.

Signature **Date**

Form Submission

Email to: claimsubmission@healthez.com

Fax to: 952-896-4888

Mail to: HealthEZ, ATTN: Claims, 7201 West 78th Street, Bloomington, MN 55439

For further assistance, call the number on the back of your insurance card.