



## Medical Expense Claim Form Miora Nevada

### 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		
			\$ Total Paid
Name of Medical Facility		Medical Facility Address	
Name of Provider		Tax ID	

### 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.

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Signature

Date

### Form Submission

Email to: [claimsubmission@healthez.com](mailto: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.