MEDALLION HEALTH

Date of Claim _____

Business or Company Name _____

Name of Employee _____

Contract Number _____

Patient's Name	Date of service	Description	Amount

* If you need more room, please fill out supplementary list

All Cheques made to 'Medallion Health in Trust'

Total Medical Expenses (Min Claim $500) _____ (A)

Admin Fee (10% of A) _____ (B)

G.S.T (5% of B only) _____ (C)

Amount for this claim (A+B+C) _____ (D)

Before your submit claim:

- ☐ have you attached your original receipts
- ☐ have you made a copy of this form and your receipts for your record
- ☐ do you declare the above claims are eligible medical expenses and the info is accurate
- ☐ Have you attached payment for amount in section "D" to fund your claim

by signing this form and submitting original receipts, I confirm that the information provided is complete and accurate to the best of my knowledge and this claim has not being paid by another plan. I hereby authorize Medallion Health to contact my service providers for whatever information is required

I acknowledge that what qualifies as an eligible expense is determined by CRA and/or other government entities, what may qualify as an eligible expense may change from time to time, and that Medallion Health is not responsible for such determinations or changes

_____ Employee Signature

_____ Date

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