MEDICAL EXPENSE REIMBURSEMENT ACCOUNT CLAIM FORM

Horizon | MyWay℠

Use this form for eligible expenses incurred by you or your eligible dependents.

☐ ✔ if this includes documentation for previously denied claim

☐ ✔ if new email address ☐ ✔ if new address

Number of pages _____

Section A – Account Holder Information (Please Print)

ACCOUNT HOLDER'S NAME LAST	FIRST	MIDDLE	SPENDING ACCOUNT ID#
MURUGAN	SENTHIL		SA

STREET ADDRESS	SOCIAL SECURITY # (if SA# not known)
110 GALWAY CIR	

CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
CHALFONT	PA	18914	9088873719

ACCOUNT HOLDER EMAIL ADDRESS	EMPLOYER NAME
senthilkmurugan@yahoo.com	MERCK

Section B – Claim Detail (Please Print)

All fields in this section must be completed. If information is missing, the processing of your claim may be delayed or denied. Supporting documentation must be attached. See the reverse side of this form for more detailed Claim Filing directions.

Date(s) of Service	Name of Person Receiving Service	Name of Provider of Service	Type of Service/ Supply Provided	Reimbursement Requested
12-11-20 to - -	Riya Senthil	L Corbett	Counseling	$ 17.94
12 18 20 to - -	Riya Senthil	L Corbett	Counseling	$ 17.94
12 04 20 to - -	Riya Senthil	L Corbett	Counseling	$ 17.94
11 24 20 to - -	Riya Senthil	L Corbett	Counseling	$ 17.94
10 29 20 to - -	Riya Senthil	L Corbett	Counseling	$ 17.94
11 06 20 to - -	Riya Senthil	L Corbett	Counseling	$ 17.94
			TOTAL	$

Section C – Account Holder Signature

I certify that the expenses listed above have been incurred by me and/or my eligible dependents and qualify as valid medical expenses according to my Summary Plan Description. These expenses have not been reimbursed and I will not seek reimbursement under my medical plan or any other health plan, such as an individual policy or my spouse's or dependent's health plan or a flexible spending account plan. I understand that the expense for which I am reimbursed may not be used to claim any Federal income tax deduction or credit. I also understand that I may be asked to provide further details about some expenses (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition or a more detailed certification from me).

ACCOUNT HOLDER SIGNATURE	DATE
[signature]	May/10/2021

Questions? Call Member Services at 1-(888) 215-0025.

Send via secured email only:
HorizonMyWay.Documents@Hellofurther.com

Fax to:
866-231-0214

Mail to:
P.O. Box 64193
St. Paul, MN 55164-0193

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Date(s) of Service	Name of Person Receiving Service	Name of Provider of Service	Type of Service/ Supply Provided	Reimbursement Requested
09-25-20~~20~~21 - -	Riya Senthil	L Corbett	Counseling	$ 17.94
07-18-20~~20~~21 - -	Riya Senthil	L Corbett	Counseling	$ 17.94
08-23-20~~20~~21 - -	Riya Senthil	L Corbett	Counseling	$ 17.94
- - to - -				$
- - to - -				$
- - to - -				$
			TOTAL	$

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