MEDIPAC ASSIST

CLIENT-PAID EXPENSE FORM

Please print clearly.
All sections must be completed in full.

SECTION A. CLAIMANT INFORMATION

Name:	Policy No.

SECTION B. PAID EXPENSES

List only **paid out-of-pocket expenses** and attach the original invoice and proof of payment for each.

- Invoices will not be processed unless original documentation is supplied. Do not send photocopies of invoices.
- Ensure that original invoices are printed on the medical facility's letterhead and include the date of service, the procedure and any diagnosis.
- If you are treated in the United States the invoice should also include the facility's federal tax ID number. A hospital bill (UB-04 with itemized statement) or doctor's bill (HCFA-Form 1500) are also acceptable original invoices.
- If you are submitting prescription receipts, provide the original client copy of any prescriptions (do **not** send in the receipt marked "duplicate").

Facility Name (Pharmacy, Doctor etc.)	Telephone # of Facility	Date of Service	Amount paid by insured	Currency

SECTION C. ADDITIONAL COMMENTS

If you receive any invoices after submitting this expense sheet, make a copy for your records and forward them directly to Medipac Assist. **Contact our office before making any payments.**

GENERAL INQUIRIES: 1-888-311-4761
SUBMIT TO: MEDIPAC ASSIST CLAIMS DIVISION, 180 LESMILL ROAD, TORONTO, ON M3B 2T5