HRA
Claim Form

Mail to: Medi-Burse, Inc.
P.O. Box 8805
Green Bay, WI 54308-8805

Amount Requested $___________________________________

Social Security # ____________________________________

Employer ____

Name ____
(print)

Address ____

City, State, Zip ____

Daytime Phone # (_____) ______________________________

□ ***Please check if new address***

Signature ____

☐ Need More Forms

www.mediburse.net

Attach explanation of benefits form.

Phone: 1-888-464-7937
(920) 465-7937
Fax: (920)465-9102
E-Mail: maggie@medi-burse.com