Medi-Burse Section 125
Medical Claim Form

Mail to: **Medi-Burse Inc.**
PO BOX 8805
Green Bay, WI 54308-8805

Amount Requested: ---------- $

Social Security Number: --------- ___ - ___ - ___

Name: ---------

Address: -------

(check if new address ☐)

City, State, Zip Code: _____, ___ _____

Daytime Phone Number: --------( ) ___ - ____

Signature:

☐ Please send more forms

Attach proper documentation for all medical expenses.

Phone: (920) 465-7937

Fax: (920) 465-9102

http://www.mediburse.net