HealthSmart PHSP Administration Ltd.
Box 335
123 Queen Street West
Toronto ON M5H 3M9

HealthSmart

Employee Claim Form

Date: _____
(yyyy-mm-dd)

ID Number: | | | | | | | | | | | | |

Employee Name: _____

Patient Relationship (Employee, Spouse, Other Dependant)	Service Date (yyyy-mm-dd)	Description	Line	Amount
			1	
			2	
			3	
			4	
			5	
			6	
			7	
			8	
			9	
			10	

If you have more expenses, please attach a supplementary sheet which can be found on the HealthSmart web site.

Total Expenses: _____

☐ Check here if additional sheets have been submitted.

Send this completed form to the address above along with:
- all receipts
- any other insurance receipts that have been received relating to the above expenses (if you have submitted these expense to other medical coverage first)

For Office Use Only

Date Received _____

Postmark Date _____

Funds Sent Date _____

Claim # | | | | | | | | |

Employee Claim v1.0