BROCK
HEALTH ADMINISTRATION LTD.

BBB ACCREDITED BUSINESS

CLAIM FORM (for Prepaid Plans Only)

Date: _____

Business or Company Name: _____

Name of Covered Employee: _____

Employee Email Address: _____

Patient Name	Service Date	Description	Amount
Use a separate sheet or spreadsheet printout if necessary. If using multiple pages, please carry forward Total Claim Amount to last page.		**Total Claim:**	$0.00

Employee certifies that all health services were purchased by or for an eligible member of their household.

Signature: _____

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