Direct Reimbursement Associates Ltd.

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PO Box 388, Pincher Creek, Alberta T0K 1W0

Claim Form for PRE-AUTHORIZED PLAN

Date: ____________________

Business or Company Name: ____________________

Name of Covered Employee: ____________________

Employee Email Address & Phone: ____________________

Patient Name	Service Date	Description of Service	Amount
		Total Claim:	$ -

Use a separate sheet or printout of this spreadsheet if necessary and carry forward each Total Claim to last page.

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

Employee Signature:____________________

GST # 87381 9478 RT0001