Provider's Statement Form

SFCoveredMRA HELP WITH YOUR HEALTH INSURANCE | SFMRA YOUR ACCOUNT FOR HEALTH COSTS

Take this form with you to your medical visit. Signatures from you and your provider are required to reimburse your MRA claim for certain expenses. Please print clearly with a blue or black pen.
Send the completed form with the signature of the health care provider and participant to:

FAX:	**MAIL:**
Spending Account Management **1(866) 643-2219** Toll-free	WageWorks Spending Accounts P.O. Box 34700 Louisville, KY 40232

Submission of this form is not a guarantee that the expense will be reimbursed.

Employee Information	
Employee name:	
Employee UID/PID:	Phone: ( ) -
Email:	
Employer:	
Employee signature:	
Date (MM/DD/YYYY):	
Employee printed name:	
Provider Information	
Patient name:	
Diagnosis/Diagnosis code:	CPT code:
Recommended treatment (must be explained in detail):	
How will the recommended treatment alleviate the diagnosis or symptoms?	
Date treatment began:	How long is the treatment required?
Additional comments:	
Provider name and title:	
Provider address:	
Phone: ( ) -	Provider license # and state:
Provider signature:	Date:

Contact WageWorks Customer Service at **1(866) 697-6078** if you have any questions about eligible MRA expenses.