Administered by:

Municipal Health Benefit Fund

Mail To:

Medical Supplies Form

MHBF
PO Box 188
North Little Rock, Ar. 72115

Please fill out one form for each member/dependent submitting claim and attach receipts

City/Entity	Social Security Number of Member
Name of Member	If Claim for Dependent, Give Name and Relationship

Nature of Illness Or Injury	Medical Supplies Required	Name of Pharmacy	Prescribing Physician	Date of Purchase	Amount charged

I hereby certify that the medical supplies were necessary for treatment of the illness/injury reported and were purchased by me for the individual named above.

Signed:_____ Date:_____

PLEASE ATTACH RECEIPTS