



Prescott College Naturopathic Benefit – Claim Form

2025

Employee: _____

Receipt #1	Receipt #2	Receipt #3
Claim for: <input type="radio"/> Employee <input type="radio"/> Spouse/Domestic Partner: _____ <input type="radio"/> Dependent: _____	Claim for: <input type="radio"/> Employee <input type="radio"/> Spouse/Domestic Partner: _____ <input type="radio"/> Dependent: _____	Claim for: <input type="radio"/> Employee <input type="radio"/> Spouse/Domestic Partner: _____ <input type="radio"/> Dependent : _____
Provider:	Provider:	Provider:
Date of Service:	Date of Service:	Date of Service:
Type of Service: <input type="radio"/> Naturopathic Doctor <input type="radio"/> Chiropractor <input type="radio"/> Acupuncture/Acupressure <input type="radio"/> Massage Therapist <input type="radio"/> Supplement(s) <input type="radio"/> Other: _____	Type of Service: <input type="radio"/> Naturopathic Doctor <input type="radio"/> Chiropractor <input type="radio"/> Acupuncture/Acupressure <input type="radio"/> Massage Therapist <input type="radio"/> Supplement(s) <input type="radio"/> Other: _____	Type of Service: <input type="radio"/> Naturopathic Doctor <input type="radio"/> Chiropractor <input type="radio"/> Acupuncture/Acupressure <input type="radio"/> Massage Therapist <input type="radio"/> Supplement(s) <input type="radio"/> Other: _____
Receipt Amt \$ (do not include tax in this amount)	Receipt Amt \$ (do not include tax in this amount)	Receipt Amt \$ (do not include tax in this amount)

Please attach applicable receipts to the back of this claim form. Thank you!

*Signature of Employee: _____ Date: _____

HR Use Only					
	Receipt #1		Receipt #2		Receipt #3
Amount:		Amount:		Amount:	
	X 75%		X 75%		X 75%
	\$		\$		\$
Sufficient Balance? <input type="radio"/> Yes <input type="radio"/> No	If no, available is: \$	Sufficient Balance? <input type="radio"/> Yes <input type="radio"/> No	If no, available is: \$	Sufficient Balance? <input type="radio"/> Yes <input type="radio"/> No	If no, available is: \$
Reimburse:	\$	Reimburse:	\$	Reimburse:	\$
Total for Reimbursement:					\$
Added to claims tracking		Claim # ____ of ____ on date: _____			
Approved by:		Check #: _____			