Approved Product Purchase Reimbursement Form

If you have purchased an approved product from a participating retailer and want to request reimbursement, please submit this form along with a copy of your receipt(s). Once verified, we will mail you a check and deduct the funds from the appropriate allowance on your smart card. All forms must be submitted by **January 31, 2025** to receive reimbursement for 2024 purchases.

To submit for reimbursement, mail a completely filled out copy of the form below, **along with a copy of your receipt(s)**, to:

Braven Reimbursements
4613 N. University Drive, #586
Coral Springs, FL 33067

First Name _____ Last Name _____

Member ID #: _____

Date of purchase: ____/____/_____ **(valid dates 1/1/2024 - 12/31/2024)**

Item name(s): _____

Retail location: _____

Reimbursement Amount: $_____

Purse funds to be deducted from: _____

Braven Health complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations. Spanish (Español): Para ayuda en español, llame al 1-833-272-8360 (TTY 711). Chinese 1-833-272-8360 (TTY 711).

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