Payment Request for Medical Related Expenses

Check one: Direct Payment
Reimburement

Do not combine requests for Direct Payment to providers and requests for Reimbursement on the same form. Use separate forms for each type of request.

Requests should be itemized below with an explanation of each listed. Original documents are required and should be marked with the corresponding number. For reimbursement requests, proof of paynent is also requred (paid receipts). If you have any questions, call the office.

Name of Patient: _____

No.	Date	Name of Business or Provider	Explanation / Description of Expenditure	Amount
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
			Total:	

I certify the above information is correct	Send reimbursement check to: (If reimbursement is Requested)
X_____ Signature of Patient or Guardian	_____ Name (Please Print)
Phone Number: _____	_____ Street Address
Date Submitted: _____	_____ City, State Zip Code