MEDICAL REIMBURSEMENT FORM

This form must be completed and submitted with a copy of the receipt(s) for reimbursement. This form is required for medical, dental, optical, and prescription reimbursement.

Reimbursement will not be provided to the employee without a copy of the receipt attached to this form. If a check needs to be sent directly to the doctor, pharmacy, etc., the invoice/bill needs to be attached to this form in order for the payment to be made.

Date: _____

Name of Employee: _____ Position: _____

Name of Patient: _____ Relationship: _____

Services rendered:

[ ] Medical [ ] Dental [ ] Optical [ ] Prescription [ ] Other _____

Check payable to: _____

Amount: _____

[ ] Approved **[ ] Denied**

Approved for payment by: _____ Date: _____

UMSI Benefits Fund Check # _____ Date: _____

Reason for Denial: _____

_____

Signature: _____ Date: _____