NEBRASKA ELEMENTAL

FORMULA REIMBURSEMENT

PROGRAM

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Reimbursement Claim Form

Name of Applicant (person who uses the formula): ________________________________

Birth Date of Applicant: ________________________________

Name of Parent/Guardian if Applicant is a Minor: ________________________________

Address: ________________________________ ☐ New Address

City/State/Zip: ________________________________

Phone Number: ____________________ Email: ________________________________ ☐ New Email

Check ALL the boxes that apply to you or your minor child for each category:

☐ My minor child or I have no private health insurance.

OR

☐ My minor child or I have private health insurance that has denied coverage of the formula.

☐ My minor child or I is not enrolled in WIC.

OR

☐ My minor child or I is enrolled in WIC but, I have purchased additional formula in excess of that provided by WIC. The attached receipts are for this formula.

☐ My minor child or I is not enrolled in Medicaid, Medicare, or other government insurance program such as Tricare.

AND

☐ I have not received reimbursement for a charitable grant.

Please remit no more than every thirty (30) days to allow reimbursement to process.

Record the total of the out-of-pocket cost being claimed $ _______________ and attached copy (ies) of receipt(s) showing date of purchase, proof of payment, product purchased, and delivery confirmation if applicable.

All statements on this Reimbursement Claim Form are true.

Signature of Applicant or Parent/Guardian if Applicant is a Minor:

________________________________ Date: ____________________

FOR OFFICE USE ONLY:

All documentation provided _____________ YES _____________NO. If no, Applicant was contacted on _________________________by ______________________

$ ___________________________________ total amount of attached receipts x 50% = $ ___________________________________ total amount to be reimbursed.

Reimbursement Approved: ____by ____