

Reimbursement Claim Form

Name of applicant (person who uses the formula) _____

Birth date of applicant _____

Applicant's Social Security Number _____

Name of parent/guardian if applicant is a minor _____

Parent/guardian's Social Security number if applicant is a minor _____

Address: _____

City/State/Zip+4: _____

Phone number: _____ E-mail address: _____

Check **ALL** the boxes that apply to you or your minor child:

I or my minor child has no private health insurance.

OR

I or my minor child has private health insurance that has denied coverage of the formula.

I or my minor child is not enrolled in WIC.

OR

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

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

I have not received reimbursement from a charitable grant.

Record the total of the out-of-pocket costs being claimed \$_____ and attach copy(ies) of receipts and proof of payment.

All statements on this reimbursement claim form are true.

Signature of applicant or parent/guardian if applicant is a minor:

_____ Today's Date: _____

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

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 _____