NEBRASKA **E**LEMENTAL

FORMULA **R**EIMBURSEMENT

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: _____

Parent/Guardian's Social Security Number 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.

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, produce purchased, and receipt/ship date.

All statements on this Reimbursement Claim Form are true.

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

_____ Date: _____

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