

### 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:

<input type="checkbox"/> My minor child or I have no private health insurance.	<b>OR</b>
<input type="checkbox"/> My minor child or I have private health insurance that has denied coverage of the formula.	

<input type="checkbox"/> My minor child or I is not enrolled in WIC.	<b>OR</b>
<input type="checkbox"/> 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.	

<input type="checkbox"/> My minor child or I is not enrolled in Medicaid, Medicare, or other government insurance program such as Tricare.	<b>AND</b>
<input type="checkbox"/> 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: \_\_\_\_\_

<b>FOR OFFICE USE ONLY:</b>
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 _____