# CLAIM FOR REIMBURSEMENT

For Medical, Pharmacy, Public Transport, and **approved** other costs (**Not Travel**)

Claimant: Claim Number: Month:

| Date | Item Description | Type | Receipt Attached | Total ($) | Recommended by Treating Doctor |
|---|---|---|---|---|---|
| | | | Yes ☐ | $ | Yes ☐ No ☐ |
| | | | Yes ☐ | $ | Yes ☐ No ☐ |
| | | | Yes ☐ | $ | Yes ☐ No ☐ |
| | | | Yes ☐ | $ | Yes ☐ No ☐ |
| | | | Yes ☐ | $ | Yes ☐ No ☐ |
| | | | Yes ☐ | $ | Yes ☐ No ☐ |
| | | | Yes ☐ | $ | Yes ☐ No ☐ |
| | | | Yes ☐ | $ | Yes ☐ No ☐ |
| | | | Yes ☐ | $ | Yes ☐ No ☐ |
| | | | Yes ☐ | $ | Yes ☐ No ☐ |
| | | | Yes ☐ | $ | Yes ☐ No ☐ |
| | | | Yes ☐ | $ | Yes ☐ No ☐ |
| | | | Yes ☐ | $ | Yes ☐ No ☐ |
| | | Total for this sheet | | $ 0.00 | |
| | | Total number of pages attached | | | |

I certify that the information I have provided is true and correct.

Signed

Date

/ /



30726 10/03/20 B