**HEALTH & SOCIAL SERVICE**
**Request for Reimbursement**
**CLAIM FORM**

**69725 E. 100 Rd.**
**Wyandotte OK 74370**
**(918) 666-7710**

**Please Read These Instructions Before Completing Your Request**

1. Member must complete **Part 1** and **Part 2**
2. Instructions for **Part 2**:
   a. If expenses were covered by any benefit plan, attach the Explanation of Benefits (EOB) along with an **original** itemized billing that includes the dates of service, services rendered, and total charges. Your insurance carrier (or a spouse's carrier or an individual plan) should pay before you request any reimbursement. Make copies for your records.
   b. If expenses are not covered by any benefit plan, attach an **original** itemized billing that includes the dates of service, services rendered, total charges, and proof of payment. Make copies for your records.
3. Read the Certification for Reimbursement, **sign and date the form**. Make a copy for your records. **Make notation if this is a direct payment to vendor**.
4. Mail the form to the address provided on this form.

## PART 1 MEMBER INFORMATION (Please Print)

| | |
|---|---|
| NAME: | ID # |
| ADDRESS: | DATE OF BIRTH: |
| DAYTIME PHONE NUMBER: | |

## PART 2 EXPENSE CLAIMS

| Member Name | Relationship | Date of Service | Name of Provider | Request Amount | Description of Service |
|---|---|---|---|---|---|
| **SAMPLE** John Doe | **SAMPLE** Son | **SAMPLE** 1/1/06 | **SAMPLE** Wal-Mart | **SAMPLE** $95.00 | **SAMPLE** Prescription (Rx) |
| | | | | $ | |
| | | | | $ | |
| | | | | $ | |
| | | | | $ | |
| | | | | $ | |
| | | | | $ | |
| | | | | $ | |
| | | | | $ | |
| | | | | $ | |
| | | | | $ | |
| | | | | $ | |
| | | | | $ | |

***There is a $25 minimum check amount.**

**TOTAL:** $ _____

### CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under the Health & Social Service Program.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, DECEIVE, FILES A CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION WILL NOT BE CONSIDERED FOR ANY SERVICES OF THIS PROGRAM. THE BUSINESS COMMITTEE RESERVES THE RIGHT TO REVOKE, SUSPEND, OR TERMINATE THE ELIGIBILITY OF ANY TRIBAL MEMBER FOR A PERIOD OF TIME, TO BE DETERMINED AND SET FORTH BY THE EASTERN SHAWNEE TRIBAL BUSINESS COMMITTEE.

SIGNATURE: _____ DATE: _____