

REIMBURSEMENT REQUEST

This Claim Form with original itemized bills & receipts and all correspondence should be mailed to:

HEALTH & SOCIAL SERVICES

10100 S. Bluejacket Rd., Ste. 1

Wyandotte OK 74370

Within 90 days of the date you first received your expenses

DO NOT submit a claim unless your total expenses meet the \$25 minimum requirement

Please complete all relevant sections of this form. Original documentation (itemized bills & receipts) must be submitted with this form. Photocopies of documents are NOT acceptable.

PLEASE NOTE: All claims must be incurred during the fiscal year (Oct 1—Sep 30.) Processing time could be delayed if proper documentation is not provided.

****IMPORTANT: For any questions about the program please call us at (918) 666-7710 or toll free at (866) 978-1352****

TRIBAL MEMBER INFORMATION (ONLY ONE MEMBER PER FORM)

Name: _____	Tribal ID #: _____
Address: _____ _____	Date of Birth: _____
E-Mail Address: _____	Address Change <input type="checkbox"/>
Phone Number Where You May Be Reached: () - _____	Work <input type="checkbox"/> Home <input type="checkbox"/> New <input type="checkbox"/>
	Telephone Change <input type="checkbox"/>

LIST ELIGIBLE SERVICES AND EXPENSES FOR YOU AND YOUR FAMILY THAT YOU HAVE NOT ALREADY CLAIMED THROUGH ANY INSURANCE, MEDICARE OR MEDICAID PLAN. ONLY LIST THE AMOUNT OF THE EXPENSES YOU HAVE TO PAY AFTER INSURANCE PAYS ITS SHARE. *PLEASE DO NOT USE HIGHLIGHTER, STAPLES OR TAPE RECEIPTS.

<u>Types of Expenses</u>	<u>Dates Incurred</u>	<u>Total Out-of-Pocket Expenses</u>
Total School Expense Reimbursement Requested	From _____ To _____	\$ _____
Total Health Care Reimbursement Requested	From _____ To _____	\$ _____
Total Orthodontic Reimbursement Requested	From _____ To _____	\$ _____
Total Auditory Devices Reimbursement Requested	From _____ To _____	\$ _____
Total Special Medical Equipment Reimbursement Requested	From _____ To _____	\$ _____
Total Burial Reimbursement Requested	From _____ To _____	\$ _____
Total Disabled/Elder Care Reimbursement Requested	From _____ To _____	\$ _____
Total Utilities Reimbursement Requested	From _____ To _____	\$ _____
Total Reimbursement Requested		\$ _____

***** IF ANY OF THESE EXPENSES WERE COVERED BY INSURANCE, ATTACH A COPY OF THE EXPLANATION OF BENEFITS FROM YOUR INSURANCE COMPANY SHOWING YOUR OUT-OF-POCKET EXPENSES, WITH PROOF OF PAYMENT. FOR EXPENSES NOT COVERED BY INSURANCE, SEND THE ORIGINAL ITEMIZED STATEMENT IDENTIFYING THE SERVICE, SERVICE DATE, TOTAL CHARGES AND ANY DISCOUNTS. IF THE REQUIRED DOCUMENTATION IS NOT ATTACHED, YOUR REIMBURSEMENT WILL BE DELAYED.**

CERTIFICATION: Signature Required *(Parent or Guardian in case of minor child)

I certify that the above expenses were incurred by me (and/or my spouse and/or eligible dependents) and have been incurred within the current fiscal year and were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement. I have attached proof of school enrollment and documentation from the school (when necessary) and the Explanation of Benefits statements from all insurance plans and a letter of medical necessity (when necessary) of these expenses.

Tribal Members Signature: _____ Date: _____

Did you remember to:

*Sign and date your reimbursement form	*Attach your receipts
*Provide proper documentation	*Make copies of all documentation for your records

Failure to complete all appropriate sections of the reimbursement form or submit legible itemized receipts/EOBs may delay the processing of your claim and may result in your claim being returned to you.