## MEDICAL REIMBURSEMENT REQUEST FORM

 Name:
 Claim No:
 Date of Injury:

## ALL RECEIPTS MUST BE ATTACHED TO THIS FORM PLEASE DO NOT WRITE IN SHADED AREAS

PURCHASE DATE	MEDICAL SUPPLIES	SORM	RX	SORM	DOCTOR VISIT	SORM	MISC	SORM
		USE		USE		USE		USE
AMT REQUESTED								
AMT APPROVED								
Total	Total			Total	Dates		From/To	
Billed Amt: Reduction Amt:			Paid: of Service:					
Reimbursement Reduction Codes								
A - Preauthorization n		<ul> <li>L - Not treating doctor</li> <li>M - Reduced to fair or reasonable amount</li> </ul>		P - Overpayment recoupment			Adjuster:	
<ul><li>D - Duplicate charge</li><li>E - Not compensable</li></ul>		N - No documentation on file		<ul> <li>R - Charge unrelated o compensable injury</li> <li>U - Unnecessary medical treatment or service</li> </ul>			Supervisor:	

## HOW TO COMPLETE FORM

\*\*Please note: This is a one-time reimbursement. All future medical treatments, supplies, and prescription are to be billed directly from the Health Care Provider to the State Office of Risk Management.\*\*

1. Date of purchase.

2. Medical Supplies:	List item purchased and amount paid. Must include copy of prescription, letter of medical necessity from doctor, and receipt.
3. RX:	List total amount paid for prescriptions. Must include copy of payment receipts and pharmacy receipts.
4. Doctor visit:	Amount paid for visit. Must include payment receipt.
5. Miscellaneous:	Must include receipts.

Sign and date form. Send to: State Office of Risk Management PO Box 13777

Retain copy for your records.