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 USE	RX	SORM USE	DOCTOR VISIT	SORM USE	MISC	SORM USE
AMT REQUESTED								
AMT REDUCED								
AMT APPROVED								

Total Billed Amt: _____ Total Reduction Amt: _____ Total Paid: _____ Dates of Service: From/To _____

Reimbursement Reduction Codes

A - Preauthorization not obtained
D - Duplicate charge
E - Not compensable
L - Not treating doctor
M - Reduced to fair or reasonable amount
N - No documentation on file
P - Overpayment recoupment
R - Charge unrelated o compensable injury
U - Unnecessary medical treatment or service

Adjuster: _____

Supervisor: _____

Claimant's Signature: _____ Date: _____

SORM-81A Rev. 2/01

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.