



## Request for Reimbursement Form

Consumer/Representative Name: \_\_\_\_\_

Representative/Consumer ID #: \_\_\_\_\_

Date of Service: \_\_\_\_ / \_\_\_\_ / 2008

### Select Service Code/Description to be reimbursed:

- Please attach a **paid** invoice to this request or a receipt including a date of the purchase and name of the item purchased.
- Select only a valid service code from your approved budget plan.

<input type="checkbox"/> 603 / Adult Dental Services
<input type="checkbox"/> 604 / Assistive Technologies
<input type="checkbox"/> 614 / Environmental Accessibility Adaptation
<input type="checkbox"/> 677 / Equipment
<input type="checkbox"/> 678 / Medical Equipment
<input type="checkbox"/> 679 / Modify Residence
<input type="checkbox"/> 680 / Modify Vehicle
<input type="checkbox"/> 681 / Other Adaptive Equipment/Devices
<input type="checkbox"/> 682 / Repairs to Medical Equipment
<input type="checkbox"/> 683 / Equipment Repairs
<input type="checkbox"/> 684 / Wheelchair Batteries
<input type="checkbox"/> 686 / Worker Training
<input type="checkbox"/> 689 / Advertisement

Amount to be reimbursed: \$ \_\_\_\_\_

\_\_\_\_\_  
Consumer/Representative Signature

\_\_\_\_\_  
Date