



IRIS Participant Reimbursement Request

Instructions: 1. Participant or guardian completes information and signs at bottom.
2. Attach receipt demonstrating the cost was paid.

Medicaid ID#: _____ Date of Purchase or Service End Date: _____

Pay For
Print Participant Name: _____

Address: _____

Phone Number: _____

Description of Purchased Goods or Services: _____ Service Code: _____

Unit Type: _____ Unit Rate: \$ _____
(each, hour, date, etc.)

of Units: _____ Amount: \$ _____

Approved: _____ Date: _____
Participant or Guardian Signature