iLIFE
Choice. With Confidence.

IRIS
Include, Respect, I Self-Direct

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

# of Units: _____ Amount: $_____

Approved: _____ Date: _____
Participant or Guardian Signature