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

P.O. Box 91760 | Milwaukee, WI 53209 | Phone: 1-888-800-5599 | Fax: 1-414-937-2034
Email: IRIS.Claims@iLIFEfms.com | Website: iLIFEfms.com

(7/2017)