iLIFE
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IRIS
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Participant Reimbursement Request

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

Medicaid ID#: 1234567890

Date of Purchase or Service End Date: 3-26-2017

Pay For
Print Participant Name: John Doe

Address: 123 W. Street

City, State 54321

Phone Number: 414-123-4567

Description of Purchased Goods or Services: Medical Supplies

Service Code: T2028

Unit Type: Each
(each, hour, date, etc.)

Unit Rate: $ 20

# of Units: 3

Amount: $ 60

Approved: John Doe
Participant or Guardian Signature

Date: 3-31-2017

Signature date must be on or after Date of Purchase or Service

SAMPLE

(7/2017)