Blind Vendor Health Insurance Reimbursement Form

GENERAL INFORMATION

Vendor Name:

Patient Name:

Date Submitted:

TYPE OF MEDICAL SERVICE

Physician Visit ☐

Dental Visit ☐

Vision ☐

Prescription ☐

Specialized Medical ☐

Psychological / Counseling ☐

Equipment ☐

Transportation ☐

SERVICES LOCATION

Name of Where Services Were Performed:

Address:

Phone Number:

VENDOR INSURANCE INFORMATION

Is Vendor / Family Member Covered by Other Insurance?

If Yes, Please Provide Insurance Information:

Total Paid by Vendor: $

Total Paid by Insurance: $

Please attach ALL receipts for the requested reimbursements.

If you or your dependents are covered by other insurance, please attach a copy of what your insurance carrier has covered.

It is the vendor's responsibility to provide proof of payment by himself / herself and / or the insurance company.