# CONSUMER CHOICES OPTION
# NON-PAYROLL REIMBURSEMENT REQUEST

CHECK PAYABLE TO:

ADDRESS:

CONSUMER NAME:

CONSUMER MEDICAID #:

*** Please note that this form needs to be filled out for each request/receipt**

| Date of Service/Purchase | Description of Service, Good or Reimbursement (a receipt/invoice must be attached) | Receipt Attached | Amount To Be Paid |
|---|---|---|---|
| | | ✓ | |
| | | ✓ | |
| | | ✓ | |
| | | ✓ | |
| | | ✓ | |
| | | ✓ | |
| | | ✓ | |
| | | ✓ | |
| | | ✓ | |
| | | ✓ | |
| | | ✓ | |
| | | ✓ | |

Total:

**No payment will be made if the reimbursement or good was not previously identified on the individual budget.**

Vendor Signature: DATE:

Member Signature: DATE:

Reimbursement requests must be submitted by the 7th day/22nd day of the month to be paid by the 15th/last day of the month

SEND TO:

**Email**
ccoiowa@veridiancu.org

**Fax**
319-236-6785

**Mail**
Veridian Fiscal Solutions
PO Box 4502
Waterloo, IA 50704