Ref. #: .278(A) .281(R)

Amount Due: $___________

Approved by: ____________

Franklin County Technical School
Medical Reimbursement Form

Member Name: ______________________________

Office co-pay reimbursement $5.00 or the full cost of your co-pay if scheduled after working day (receipt must show time of appointment)

Amount Due

Date of office visit ________________ _______

Date of office visit ________________ _______

Date of office visit ________________ _______

Date of office visit ________________ _______

Total Due _______

Prescription reimbursement- Mail in prescriptions only

	You Paid:	Reimbursable amount:
Tier I	$20.00	$10.00
Tier II	$50.00	$ 25.00
Tier III	$90.00	$ 45.00

Date of prescription ________________ _______

Date of prescription ________________ _______

Date of prescription ________________ _______

Date of prescription ________________ _______

Date of prescription ________________ _______

Total Due _______

Emergency Room reimbursement $ 25.00

Date of emergency room visit ________________ _______

Attached receipts to this form