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

Amount Due: $_____

Approved by: _____

Franklin County Technical School
Medical Reimbursement Form

Member Name: _____

Prescription reimbursement- Mail in prescriptions only. Attached receipts to this form

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

	Date	Amount Due
Date of prescription	_____	_____
Date of prescription	_____	_____
Date of prescription	_____	_____
Date of prescription	_____	_____
Date of prescription	_____	_____
Date of prescription	_____	_____
Date of prescription	_____	_____
Date of prescription	_____	_____
Date of prescription	_____	_____
Date of prescription	_____	_____
Date of prescription	_____	_____
Date of prescription	_____	_____
Date of prescription	_____	_____
Date of prescription	_____	_____
Date of prescription	_____	_____
Total Due		_____