

WASHTENAW COMMUNITY COLLEGE  
Office of Human Resource Management

**Faculty  
Request for Medical Reimbursement**

Employee ID: @ \_\_\_\_\_

Employee Name: \_\_\_\_\_  
Last First M.I.

Position: \_\_\_\_\_

Department: \_\_\_\_\_

Amount of reimbursement: \$ \_\_\_\_\_

I hereby certify that on (date) \_\_\_\_\_, I received and paid  
the attached medical bill from (provider's name) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
*Employee's Signature*

\_\_\_\_\_  
*Date*

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Medical services must be rendered between 08/25/2009 and 08/24/2012*

**All from must be in HRM no later than 09/08/2012**  
*Human Resource Use Only*

**Processed to Payroll by:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Total cost of services:** \_\_\_\_\_

**Less BCBS Payment:** \_\_\_\_\_

**Subtotal:** \_\_\_\_\_

**Reimbursement:** \_\_\_\_\_