WASHTENAW COMMUNITY COLLEGE
Office of Human Resource Management

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) ____________________

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_______________________________________ ________________________

Employee's Signature ***Date***

Notes: ____

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Medical services must be rendered within the 7/1/09 and 6/30/10 fiscal year.

All forms must be delivered to HRM no later than 7/15/10

Human Resource Use Only

Processed to Payroll by: _______________________________________

Date: ________________________________

Total cost of services: ________________________________

Less BCBS Payment: ________________________________

Subtotal: ________________________________

Reimbursement: ________________________________