Lee's Summit R-7 School District
Medical Claim Form

NAME _____ BUILDING _____

EMP ID# _____ DATE _____

To receive a direct deposit reimbursement on payday -
claims must be received at least four (4) working days before payday.

MEDICAL EXPENSE CLAIMS

Date(s) of Service MM/DD/YY	Requested Amount of Reimbursement	Type of Service Prescription, OTC, Eye Care, Dental, Dr. Copay,	Date(s) of Service MM/DD/YY	Requested Amount of Reimbursement	Type of Service Prescription, OTC, Eye Care, Dental, Dr. Copay,

$_____ Total

$_____ Total

$_____ Claim Total

$_____ Total Reimbursed

Read Carefully: I certify that these eligible expenses have been incurred by me; my spouse or eligible dependent and medical expenses are not for cosmetic purposes but for the treatment of an illness, injury, trauma, or medical condition. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim. This expense will not be reimbursed by any other cafeteria plan, medical plan/policy or government agency.

Employee's Signature _____ **Date** _____

(required to process claim)