

WORKER'S MEDICAL EXPENSE STATEMENT

If you require reimbursement for medical expenses, please complete and return this form.

1. Please fully complete Part 1 and Part 2.
2. Attach ORIGINAL receipts for all expenses being claimed.
3. Please use a separate sheet if additional space is required.

Incomplete information will mean a delay in processing. Please ensure both parts are complete and accurate, and that all original receipts are attached.

PART 1

<u>Prescription Name & Number</u>	<u>Date Expense Incurred</u>	<u>Amount Paid</u>
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

PART 2

Name: _____ Claim Number: _____

Address: _____

Signature

Date