

## **Enriching Lives Everyday**

## Transplant Fundraising Program Reimbursement Request Form

lame				
ransplant Center/Organ:				
ransplant Date (if applicable	e)			
eimbursement request for: □ Pr ☐ Other transplant related expens	rescription Medicine	Premiums □ Travel □ N	ledical expenses	
<b>latched account clients only</b> - Pleas asurance premiums is \$1,000. Please rograms first. Please refer to your gu		nt. When applicable, clients are en	prescription medicine and medical couraged to utilize GTF assistance	
Prescription Medica	ations (include proof of your payment)			
Pharmacy	Date of Service	Amount paid	Proof of Payment	
			\$	
Medical Insurance Premiun	ns: check payable to: Provide	r Myself		
Provider	Coverage Months  No more than 3	Amount to	Amount to be paid	
Total		\$		
There is a \$2000 Maxim matching funds)	num Lifetime Reimbursement for the follow	ing expenses: (\$1000 of you	r funds and \$1000 of GTF	
	Co-pay amounts, labs, treatments, or home n payment should be included.	nedical. These paid expenses a	are reimbursed to the client.	
Provider	Dat	e Amo	ount paid	
Total		\$		

<u>Travel</u>	Please include original	receipts and proof of medi-	cal appointment such	as parking or hospital	admission/discharge papers
or office	visit paperwork				

Date of Travel	Expense: Gas/Hotel/Parking	Amount	Destination and Purpose
Total		-	\$
Other Requests:			
			reimbursement. Anything not listed in eligible
expenses must be	a medical expense and <b>pre-</b>	approved.	
Signature			Date
Mail this form, you	ur supporting documents &	&receipts to	
			TFP
			2201 Macy Dr. Roswell, GA 30076
			,
Date Processed:	Raim	nhursement A	Amount: