|  |  |
| --- | --- |
| [Company Name] [Street address]  [City, ST ZIP Code] | [Contact information for Privacy Official] |
| Medical Treatment Reimbursement FormPATIENT INFORMATION |  |
|  | Date |
|  |  |
| Card Holder’s Name (Last, first, middle initial) | Social Security # or Patient ID |
|  |  |
| Card # | Valid until: |
|  |  |
| Street address, City, ST, ZIP Code | Email address |

**Diagnosis**

|  |
| --- |
|  |
|  |
|  |
|  |

**If hospitalized:**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Hospital Name & Date of Admission |  | Discharge Date |
|  |  |  |
| Hospital Name & Date of Admission |  | Discharge Date |
|  |  |  |
| Signature of Authorization |  | Date |
| **Case Management & Actual Cost** | | |
|  | | |
|  | | |
|  | | |

**Treatment Plan**

|  |  |
| --- | --- |
| Diagnostic Tests | Pharmaceuticals |
|  |  |
|  |  |
|  |  |

Date Cardholder’s signature

**Physician’s Name**

**Telephone No.**   **Physician’s Stamp and Signature**

**Date**