Insurance Deductible Reimbursement Request Form

Jason's Friends Foundation

Family Name: _____
Mailing Address: _____
_____
Phone: _____
Date: _____

1701 East E Street, Ste 100
Casper, WY 82601
Office: (307) 235-3421
Email: info@jasonsfriends.org

PLEASE SUBMIT THE FOLLOWING DOCUMENTATION WITH EACH REQUEST:

- A copy of the billing statement for each charge listed below
- The Explanation of Benefits (EOB) from your insurance company with dates of service for each charge listed below, the child's individual annual deductible, and the amount of each payment that was applied to your child's deductible
- Proof of payment for each charge listed below

DATE	LIST EACH MEDICAL DOCTOR/CLINIC/HOSPITAL LOCATION AND PURPOSE	AMOUNT
	TOTAL	

PLEASE TELL US ABOUT THE ABOVE MEDICAL APPOINTMENTS FOR YOUR CHILD AND WHY FINANCIAL ASSISTANCE IS BEING REQUESTED TOWARDS YOUR DEDUCTIBLE.

_____
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