COPAY REIMBURSEMENT FORM

CLAIMANT'S NAME: _____

ADDRESS: _____

EMPLOYER: _____

CLAIM NUMBER: _____

DATE OF BIRTH: _____ **DATE OF ACCIDENT: _____**

DATE:	MEDICAL PROVIDER:	AMOUNT OF COPAY:	TOTAL:
		TOTAL REIMBURSEMENT:	**$**

This is a true an accurate account of my expenses. Such expenses were incurred for medical costs as a result of my work-related injury only. I am aware it is against the law for any person to knowingly misrepresent any fact in order to obtain worker's compensation benefits. I hereby sear and affirm under the penalties of perjury that the facts listed above are true and correct to the best of my knowledge.

CLAIMANT'S SIGNATURE: _____ DATE: _____