# Blind Vendor Health Insurance Reimbursement Form

Vendor Name _____

Patient Name _____

Date Submitted _____

Type of Medical Service

| | | | |
|---|---|---|---|
| Physician Visit | ☐ | Specialized Medical | ☐ |
| Dental Visit | ☐ | Psychological/Counseling | ☐ |
| Vision | ☐ | Equipment | ☐ |
| Prescription | ☐ | Transportation | ☐ |
| Health Insurance | ☐ | | |

Name, Address and Phone Number of Where Services Were Performed

_____

_____

Is Vendor / Family Member Covered by Other Insurance? ☐ Yes ☐ No

If Yes, Please Provide Insurance Information

_____

Total Paid by Vendor $_____

Total Paid by Insurance $_____

**Please attach <u>ALL</u> receipts for the requested reimbursements.**

**If you or your dependents are covered by other insurance, please attach a copy of what your insurance carrier has covered.**

**It is the Vendor's responsibility to provide proof of payment by himself / herself and / or the insurance company.**