



Choice. With Confidence.

## IRIS Participant Reimbursement Request

**Instructions:** 1. Participant or guardian completes information and signs at bottom.  
2. Attach receipt demonstrating the cost was paid.

Medicaid ID#: \_\_\_\_\_ Date of Purchase or  
Service End Date: \_\_\_\_\_

Pay For  
Print Participant Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

Description of Purchased  
Goods or Services: \_\_\_\_\_ Service Code: \_\_\_\_\_

Unit Type: \_\_\_\_\_ Unit Rate: \$ \_\_\_\_\_  
(each, hour, date, etc.)

# of Units: \_\_\_\_\_ Amount: \$ \_\_\_\_\_

Approved: \_\_\_\_\_ Date: \_\_\_\_\_  
Participant or Guardian Signature