iLIFE

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

P.O. Box 80439 | Milwaukee, WI 53208 | Phone: 1-888-800-5599 | Fax: 1-414-918-8213
Email: IRIS.Claims@iLIFE.org | Website: iLIFE.org