



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#: 1234567890 Date of Purchase or Service End Date: 3-26-2017

Pay For Print Participant Name: John Doe

Address: 123 W. Street

City, State 54321

Phone Number: 414-123-4567

Description of Purchased Goods or Services: Medical Supplies Service Code: T2028

Unit Type: Each Unit Rate: \$ 20  
(each, hour, date, etc.)

# of Units: 3 Amount: \$ 60

Approved: John Doe Date: 3-31-2017  
Participant or Guardian Signature

**Signature date must be on or after Date of Purchase or Service**

SAMPLE