CONSUMER CHOICES OPTION
NON-PAYROLL REIMBURSEMENT REQUEST

CHECK PAYABLE TO:

ADDRESS:

CONSUMER NAME:

CONSUMER MEDICAID #:

*** Please note that this form needs to be filled out for each request/receipt**

Date of Service/Purchase	Description of Service, Good or Reimbursement (a receipt/invoice must be attached)	Receipt Attached	Amount To Be Paid
		✓	
		✓	
		✓	
		✓	
		✓	
		✓	
		✓	
		✓	
		✓	
		✓	
		✓	
		✓	

☐ Check here if these purchases are to be paid for out of savings.

No payment will be made if the reimbursement or good was not previously identified on the individual budget.

EMPLOYEE SIGNATURE: DATE:

CONSUMER SIGNATURE: DATE:

Reimbursement requests must be submitted by the 7th day/22nd day of the month to be paid by the 15th/last day of the month

SEND TO: VERIDIAN CREDIT UNION
1827 ANSBOROUGH AVENUE
WATERLOO, IA 50704-6000
FAX_319-236-6785