Medical Expense Reimbursement Request Form for Jesuit Volunteers Serving in the U.S.

Choose **one** of the following methods of payment. You may submit several reimbursement requests on one form, but please submit a **separate request for each bill payment request** (given the particular information necessary for JVC to pay a bill on your behalf).

1. Pay the amount to the medical or dental provider with personal funds and request reimbursement by checking the "Reimbursement for bill already paid" box, placing your full name (no nicknames) and address in the Pay To field, including the date of service, type of service and amount to be reimbursed. Attach the receipt for payment to the form. **JVC cannot reimburse without receipt of payment.** You may place several reimbursements on one form
2. Request that JVC pay the medical provider directly. Check the "Bill to be paid" box and include the bill's due date. Send this form, the bill, and the return envelope, if provided. **JVC cannot pay a bill without a copy of original bill.** Only one bill per form and do not combine a bill with reimbursements, please.

***Note about EOBs**: If you are submitting a medical reimbursement/bill that is not for a co-pay amount (typically $20 for doctor, $10/$25/$40 or $25/$60/$100 for prescription), or if you are submitting a dental reimbursement/bill of any amount, **please also include the Explanation of Benefits** (EOB) provided by Christian Brothers*. This should have been mailed to you, but can also be found online by setting up an online account at www.mycbs.org/health.

Volunteer Name_____ Program Office_____ Date of Request _____

Volunteer email address_____ Volunteer cell #_____

❑**Reimbursements for expense already paid** OR ❑ **Bill to be paid** Due Date:_____
You may list several reimbursements on one form — One bill per form, please

Pay To Name (please use full name): _____

Pay To Address: _____

Pay To City, State, Zip: _____

❑**Check here to indicate that you have already submitted this request to JVC and attach a note of explanation.**

	Date of Service *(appointment or prescription purchase)*	***M** for medical* ***Rx** for prescription* ***D** for dental*	***Amount requested***
1			*$*
2			*$*
3			*$*
4			*$*

For multiple reimbursements, please number receipts/ EOBs

TOTAL $_____

Submit form and necessary paperwork (receipt, bill, EOB, etc.):
By email to jvhealthinsurance@jesuitvolunteers.org
By fax to 410 -244-1766 (Attn: Vol Med Reimbursement)
By mail to: Vol Med Reimb, JVC, 801 St. Paul St., Baltimore, MD 21202

JVC Office Use Only:

Balance Before Reimbursement _____ Balance After Reimbursement _____

Authorization: _____ Date of Authorization: _____