

If faxing, please do not mail

Please PRINT using black ink

MRCI
Fiscal Support Entity
Reimbursement Claim Form

Consumer _____ County _____

Representative (if applicable) _____ Phone _____

Address _____

City/ State _____ Zip Code _____

Table with 5 columns: Date Purchased or Service Provided, Item/ Service, Quantity, Cost/ Item, Total Cost. Contains 6 empty rows for data entry.

Make check payable to _____

- Send reimbursement to Consumer
Send attached invoice or order form with payment
Send reimbursement to Representative
Send check to:
Additional instructions: _____

Name _____

Address _____

City/State _____

Zip Code _____

By signing this form, I agree that if I am requesting reimbursement for a payment I made to a contract worker or respite provider, I am responsible for providing a 1099 to that individual.

Date

Signature of Consumer/Representative

Instructions:

- 1. Receipt, invoice or order form must be attached in order for claim to be processed.
2. Complete a separate sheet for each payee.
3. Fax toll-free using 1-888-800-7336.
4. If not faxing, mail to:

MRCI-Mankato
Attention: EOR
P.O. Box 328

Office use only

Authorized by _____
Billing code _____
G/L category _____
Excel _____