

**REIMBURSEMENT REQUEST FORM FOR EXTENDED HEALTH SERVICES PROVIDED TO POLIO SURVIVOR MEMBERS OF THE WILDROSE POLIO SUPPORT SOCIETY**

*To be completed by the WPSS member unless otherwise indicated. Please print clearly. Original receipts must be attached for all expenses. Please retain copies for your file as originals will not be returned. Any information provided or collected will be retained in a Member Benefits confidential file.*

***Note: Reimbursement for services is limited to available funds and not guaranteed by the Wildrose Polio Support Society. Reimbursement is usually made quarterly.***

Member's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Type of Service Provided	Date of Service	Total Charge	Amount Paid by Other Sources	Amount to be Reimbursed
Total Reimbursement Requested:				\$

I certify that these expenses meet the following conditions:

- I have received all services claimed and that the information provided is true and complete, the services listed were received on the date(s) listed above, and
- I have not been reimbursed for these expenses in any way.

I understand that reimbursement of these expenses may only be requested after I have exhausted all benefits available from all plans through which I am covered. I further certify that I have not claimed, nor will I claim a deduction on my individual tax return, for any of the expenses reimbursed through this program.

Member's Signature: _____	Date: _____
Provider's Signature: _____	Date: _____

Please issue payment to: Member \_\_\_ Provider \_\_\_

Name and Address of Service Provider:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please mail completed form with receipts to:  
 Wildrose Polio Support Society  
 132 Warwick Road NW  
 Edmonton, Alberta T5X 4P8