

# Sutton Teachers' Association Medical Insurance Reimbursement Form

STA Member \_\_\_\_\_ Building \_\_\_\_\_

Position \_\_\_\_\_ Date \_\_\_\_\_

Health Plan \_\_\_\_\_ Insurance Number \_\_\_\_\_

Office Visits: (List dates) \_\_\_\_\_

Cost per visit prior to July 1, 2005 \_\_\_\_\_

Cost per visit after July 1, 2005 \_\_\_\_\_

Difference \_\_\_\_\_

Difference \$ \_\_\_\_\_ times number of visits listed above \$ \_\_\_\_\_ (must include receipts)

Emergency Room Visits: (List dates) \_\_\_\_\_

Cost per visit prior to July 1, 2005 \_\_\_\_\_

Cost per visit after July 1, 2005 \_\_\_\_\_

Difference \_\_\_\_\_

Difference \$ \_\_\_\_\_ times number of visits listed above \$ \_\_\_\_\_ (must include receipts)

Prescription Co-Pay: (Number of prescriptions purchased) \_\_\_\_\_

Cost per prescription prior to July 1, 2005 \_\_\_\_\_

Cost per prescription after July 1, 2005 \_\_\_\_\_

Difference \_\_\_\_\_

Difference \$ \_\_\_\_\_ times number of prescriptions listed above \$ \_\_\_\_\_ (must include receipts)

Signature \_\_\_\_\_