Georgia Transplant Foundation

Enriching Lives Everyday

Transplant Fundraising Program
Reimbursement Request Form

Name ____

Transplant Center/Organ: ____

Transplant Date (if applicable) ____________________________

Reimbursement request for: ☐ Medicine ☐ Medical ☐ Day Travel ☐ Extended Stay Housing ☐ Other transplant related

Matched account clients only *- Please note that the maximum reimbursement for* ***post-transplant*** *expenses other than prescription medicine is $1,000. Please note that funds raised are matched post-transplant. When applicable, clients are encouraged to utilize GTF assistance programs first.*

Medications (please include original receipts/proof of payment)

Pharmacy	Date	Amount paid
Total		$

Medical (please include original receipts/proof of payment)
(lab fees, co-pays, medical insurance premiums [for the patient], treatments and home medical supplies/equipment)

Provider	Date	Amount paid
Total		$

Day Travel (please include original receipts and proof of appointment)

Date of Travel	Gas Costs	Destination and Purpose
Total		$

Extended Stay Housing

Hospital ____ Date of admission _________________________

Required local stay beginning on ____

Number of days ____________________ Number of People ☐ 1 ☐ 2

Hotel/Housing Accommodations $___________________

Parking/Tolls $___________________

Other expenses (explain fully) $___________________

Total Travel Expenses $___________________

Other Requests:

Please describe any additional items you are submitting for reimbursement.

Please include original receipt.

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Signature ____ Date ____________________________

Mail this form and your receipts to:

GTF, 500 Sugar Mill Rd., Suite 170-A, Atlanta, GA 30350