Georgia Transplant Foundation

Enriching Lives Everyday

Transplant Fundraising Program

Reimbursement Request Form

Name _____

Transplant Center/Organ: _____/_____

Transplant Date (if applicable) _____

Request Date _____ **Total Amount of Entire Request**_____

Reimbursement request for: ☐ Prescription Medicine ☐ Medical Insurance Premiums ☐ Travel ☐ Medical expenses ☐ Other transplant related expenses

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

Prescription Medications *(Include Itemized Receipts. Attach additional pages if needed.)*

Pharmacy	Date of Service	Amount paid	Proof of Payment
			$

Medical Insurance Premiums: check payable to: ☐ **Provider** ☐ **Myself**
(Include Proof of Payment to receive personal reimbursements)

Provider	Coverage Months No more than 3	Amount to be paid
Total		$

Medical Expenses: Co-pay amounts, labs, treatments, or home medical. These paid expenses are reimbursed to the client. *(Include original receipts/proof of payment).*

Provider	Date	Amount paid
Total		$

Travel: *(Include original receipts and proof of medical appointment* such as parking or hospital admission/discharge papers or office visit paperwork)

Date of Travel	Expense: Gas/Hotel/Parking	Amount	Destination and Purpose
Total			$

There is a $2000 Maximum Lifetime Reimbursement for Medical Expenses & Travel Expenses: ($1000 of your funds and $1000 of GTF matching funds)

Other Requests:

Please describe any additional items you are submitting for reimbursement. Anything not listed in eligible expenses must be a medical expense and **pre-approved.**

Signature _____ Date _____

PLEASE NOTE: Reimbursements are processed after the 15th of every month. Any reimbursement requests received after the 15th will be processed with those of the following month.

Mail this form, your supporting documents &receipts to:

Georgia Transplant Foundation
TFP
2201 Macy Dr.
Roswell, GA 30076

Date Processed: _____ Reimbursement Amount: _____

Edited 8/24/2021