Tribal Healthcare Expense/Reimbursement Agreement

Tribal Member Printed Name:_____

Date:_____ Amount of the request: _____

(Please select the box that best fits your request)

I am requesting funding assistance for:

- ❒ **Expense**
- ❒ **Reimbursement**

(Please Check the Category of the Expense and attach proof of cost or expense along with this form.)

- ❒ **Co-pays for Medication & Private Insurance**
- ❒ **Out of Pocket Prescription Costs:**
- ❒ **Eyewear/Glasses:**
- ❒ **Orthopedics:**
- ❒ **Physical Therapy:**
- ❒ **Orthodontics/Oral-surgery**
  Dentures/Partials/Braces/Wisdom Teeth
- ❒ **Other Non-Cosmetic Health Provider Services**

Payable To: _____

Address To Be Sent To: _____

_____

_____ _____ _____

Tribal Member Signature Date Phone Number:

Approval:

_____ _____

Tribal Chairperson/Administrator Date

Tribal Office Number: (530) 473-3274
Tribal Fax Number: (530)473-3301

Note: Attach Invoice Copy To The Back