FONTANA UNIFIED SCHOOL DISTRICT
Fiscal Services/Benefits Office

Reimbursement of Medical Co-Payment Receipts

Please attach the original receipt(s) to this form, fill in the appropriate blanks, mail or hand carry to the Benefits Office located at 9680 Citrus Avenue, Fontana, CA 92335. If you have any questions regarding this form, please call (909) 357-5000, Ext. 7016. Your reimbursement check will be sent to your home address.

Employee's Name:______________________________

Address:______________________________

❒ Check if your address has changed

Daytime Phone or Extension:______________________________

Date of Service and Amounts:

Date of Service	Amount
__________	$________
__________	$________
__________	$________
__________	$________
__________	$________
__________	$________
__________	$________
__________	$________
__________	$________
__________	$________
TOTAL	$________

I certify that I am entitled to receive Medical Co-payment reimbursement.

____________________ __________
Employee's signature Date

For F.U.S.D. Office Use Only

Account# to charge: 01 – 0000 – 0000 – 7200 - ___ ___ ___ ___ - 000 – CPAY

____________________ __________
Approval of Benefits Office Date