DIVISION OF SPECIALIZED CARE FOR CHILDREN

FAMILY REIMBURSEMENT COST LOG

PAYEE'S NAME AND COMPLETE MAILING ADDRESS

PARTICIPANT NAME _____

DSCC NUMBER _____

To receive reimbursement, this cost log must be returned to your University of Illinois Chicago Division of Specialized Care for Children (DSCC) Regional Office WITH RECEIPTS. DSCC will only approve costs related to a participant's DSCC Core eligible medical condition.

DATE OF SERVICE OR PURCHASE (Please list in date order)	DESCRIPTION OF SERVICE, ITEM, EVENT OR MEDICATION RX NUMBER	WHO DID YOU PAY?	AMOUNT PAID
		TOTAL REIMBURSEMENT	**$**

I certify that the listed amounts were paid to the identified providers for prescribed medications, services, or items on behalf of the DSCC participant.

PAYEE'S SIGNATURE _____ DATE _____

DSCC USE ONLY

Payee name and address must match information on record.

Payee: Applying LRA ☐ ☐ Spouse in Same Household ☐ Other (must be enrolled)

I approve reimbursement for the listed medications, items, or services and verify they are related to the Core eligible medical condition and are consistent with DSCC polices.

CARE COORDINATOR/PCA CERTIFICATION _____ DATE _____

RM/ARM APPROVAL _____ DATE _____

(For RO address stamp)

********See reverse side for detailed instructions********

TO BE REIMBURSED FOR APPROVED EXPENSES:

- Talk to your Care Coordinator to make sure the expense is eligible.
- Complete items 1-8 as described below.
- Sign and date the form.
- Send a receipt for each item, medication, or event. The receipt must show that payment was made.
- Please send this reimbursement form within **30 days** from date of service.
- Payment can be made to the legally responsible adult who applied for financial assistance or to that person's spouse who lives in the same household. Additional paperwork is needed to pay anyone else.

HOW TO COMPLETE THIS FORM:

1. **PAYEE'S NAME AND COMPLETE MAILING ADDRESS:** Enter name and mailing address of the person to receive payment.
2. **PARTICIPANT NAME AND DSCC NUMBER:** Enter the participant's name and the six-digit DSCC number.
3. **DATE OF SERVICE:** Write the date the prescription was filled, the date medical services were provided, or the date payment was made for educational events or materials (month-day-year). Please list in date order.
4. **DESCRIPTION OF SERVICE, ITEM, EVENT OR MEDICATION RX NUMBER:** Enter the Rx number, name of over-the-counter medication, or describe the service, event, or item.
5. **WHO DID YOU PAY:** Write the name of the pharmacy, store, or business that was paid.
6. **AMOUNT PAID:** Write the amount you paid for the medication, other prescribed item, or medical services.
7. **TOTAL REIMBURSEMENT:** Write the total of all amounts paid.
8. **PAYEE'S SIGNATURE AND DATE:** Signature of the person who is listed at the top of form and who will receive reimbursement. Enter the date the Cost Log was signed.
9. **CARE COORDINATOR/PCA CERTIFICATION AND DATE: Don't write in this space**. (To be signed by DSCC staff)
10. **RM/ARM APPROVAL AND DATE: Don't write in this space**. (To be signed by the manager)

HAVE YOU…

- For prescription medications- included the original drug receipt and/or pharmacy print-out?
- For over-the-counter medications- included an itemized cash register receipt?
- For co-payments- included the receipt from the provider that shows the co-pay was paid?
- For all other expenses- included the itemized receipt that shows payment was made to whom and for what?
- Completed the front side of form including signing and dating?

MAIL TO:

Address on the front of this form.

NEED HELP?

Call or email your DSCC Regional Office.