

Prescription and Mileage Reimbursement

Request must be received by FPDR within 60 days of incurring expense

Member Information

Name (printed)	Email	Phone
Home address		
City	State	Zip
<input type="checkbox"/> Fire <input type="checkbox"/> Police	Claim Number	Injury date and time
Brief description of injury		

Request for prescription reimbursement requires original label and receipt

RX Fill Date	Medication	Doctor/Provider	Cost
Total Cost			

Request for mileage

Travel Date	Destination Name and Address	Miles
Total Miles		

Applicant's statement: I hereby affirm this request for reimbursement is true and is related to my approved claim.

Signature _____ Print name _____ Date _____

FPDR staff: Total mileage _____ x _____ /mile = \$ _____ Grand total due to member \$ _____

Please sign and mail, fax, or email form to FPDR.

