MEMBER REQUEST FOR REIMBURSEMENT OF ADOPTION EXPENSES

This form should be completed if a member has paid out of pocket for adoption expenses and is requesting reimbursement as these expenses may be eligible for sharing.

PERSONAL INFORMATION (please print clearly)

PRIMARY CONTACT		Membership ID	
Address			
City		State	Zip + 4
Home Phone	Member/Patient Name That Incurred Expenses		

ADOPTION EXPENSES

Description of Expenses	Date of Service (MM/DD/YYYY) From	To	Amount Charged	Amount Paid by Member	Bill or proof of payment attached
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
		TOTAL CHARGED		**TOTAL FOR CONSIDERATION**	

SIGNATURE	Date

ADOPTION EXPENSES (Guideline Section III):

Attach documentation reflecting the final legal adoption, as well as bills and/or statements with charges that may include legal, medical, travel, hospital fees, and adoption agency fees.

✓ **Copy of legal documentation that adoption is legally finalized**

✓ **Copies of bills or statements relating to adoption expense**

BILLS MISSING ANY OF THIS INFORMATION MAY BE RETURNED TO YOU

Please mail this completed form along with the requested documents/receipts to:

Impact Health Sharing | PO Box 3139, Farmington Hills, MI 48333 | (855) 378-6777 | Fax (954) 678-6970