Ravena Coeymans Selkirk CENTRAL SCHOOL DISTRICT
INDIANS

MEDICAL REIMBURSEMENT CLAIM FORM

NAME:_____ **BUILDING:**_____

ADDRESS: _____

PLEASE SUBMIT ALONG WITH VERIFICATION OF PAYMENT TO THE BUSINESS OFFICE.
THE FORM WILL BE RETURNED IF NOT COMPLETED CORRECTLY OR PAYMENT VERIFICATION IS NOT ATTACHED.

- **Inpatient Maternity Stay: $250 per admission ~ refunded 1 x every 12 months**

_____ **x $250 =** _____
(number) (Total)

- **Diabetic Supplies and Services: District will reimburse $5 for every $25 when paid through BSNENY.**

_____ **x $5 =** _____
(number) (Total)

_____ _____
Employee Signature Date

_____ _____
District Office Administrator Date