

# RETIREE PRESCRIPTION REIMBURSEMENT

Name:

Address:

Phone:

Pharmacy	Date of Service	Amount Paid	Amount Reimbursed
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Total Amount Paid:

Amount Reimbursed (\*To be filled out by HR Director):

\_\_\_\_\_  
Retiree Signature

Date Signed:

\_\_\_\_\_  
Theresa Tourville

Date Processed: