LAW OFFICE OF
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OUT-OF-POCKET REIMBURSEMENT REQUEST

To Claims Adjuster
Name:
Address:

RE: Applicant Name: ___________________ v Employer: ___________________
WCAB NO: ___________________ CLAIM NO: ___________________

Below represents medical treatment costs incurred "Out-of-Pocket" by myself for treatment because of my industrial injury. Please forward a reimbursement check immediately.

Date	**Item Purchased**	**Purchased From**	**Prescribed By**	**Item Cost**	**Other/Note**
Sample: 01/06/14	Sample: Pain pills	Sample: Pharmacy ABC	Sample: Dr. Joe Smith	Sample: $45.05	Sample: See RX from Dr. Smith
Applicant Signature:					
Completion Date:					
California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.				$	**Total Reimbursement Requested**