REIMBURSEMENT REQUEST FORM

This section to be completed by participant/ or parent/ or guardian

All items reimbursed under the CDS option must be included on the signed budget received by the office prior to the purchase being made. By submitting this reimbursement request and signing below I understand that the items purchased and reimbursed for must be for CDS use only.

____ **Date:** ______________________

Participant or Employer Signature Acknowledgement (required)

Participant Name: _______________________________________ **Receipt Date:** __________

Check payable to: _______________________________________ **Date Submitted:** __________

Name of person Submitting request: _______________________________________ **Amount requested: $** __________

Description of purchase: ____

____

____

Mail check to: ____

THIS SECTION FOR CDS OFFICE USE ONLY

Approved by: ___________________________ **DATE**__________

Processed by: ___________________________ **DATE**__________

CHECK # ____________ **AMOUNT $**_________________ **DATE**__________

____ **ENTERED IN BUDGET** **PLAN YR TO BE BILLED:** _______________ **TO** _______________

____ **ENTERED IN A/P** **MAILED/FAXED**________ **RECEIVED**_________

NOTES: ____

____

Billing

Program: ___ **CLASS** ___ **DBMD** ___ **STAR Kids MDCP** ___ **PHC** ___ **HCS** ___ **TxHmL**

___ **STAR+PLUS** ___ **SPW** ___ **non SPW** ___ **PCS Foster** ___ **PCS STAR Kids** ___ **PCS (HHSC)**

Billing Date: ____________ **Unit Cost:** _________ **Qty:** _________ **Bill amount:** __________

Email: AccountsPayable@cdsintexas.com

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Toll Free Phone: 866-301-0931 Fax: 877-726-4919