



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.

Participant or Employer Signature Acknowledgement (required) Date:
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:
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
SPW
STAR+PLUS non SPW PCS Foster PCS STAR Kids PCS (HHSC)
Billing Date: Unit Cost: Qty: Bill amount:

Email: AccountsPayable@cdsintexas.com 6243 IH-10 West, Suite 430, San Antonio, Tx, 78201

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