2009-2010 Student Request for Medical/Dental/Nursing Home Expense Adjustment

THE UNIVERSITY OF IOWA
Office of Student Financial Aid
208 Calvin Hall
Iowa City, Iowa 52242-1315

(319) 335-1450
(800) 553-4692
E-Mail: *financial-aid@uiowa.edu*

______________________________________ Student's Name (please print)

____________________ UI ID Number

Complete this form if you have incurred medical/dental/nursing home expenses that you would like us to review for an increase in your cost of attendance. **If your expenses are for routine medical/dental check-ups, elective procedures, or cosmetic surgery, do not complete this form**. We will not consider routine expenses because they have already been included in your cost of attendance.

If expenses are not itemized, this form will be returned to you for completion.

For returning students, we will consider expenses incurred and/or paid June 2009 through May 2010. **For newly admitted students or transfer students**, we will consider expenses incurred and/or paid beginning with your first term of enrollment at the University of Iowa through May 2010.

List only medical/dental/nursing home expenses below. See the other side of this form for instructions on prescription expenses. Attach an additional page, if necessary.

Medical/Dental/Nursing Home Expenses

If submitting multiple expenses, you must itemize them on this form. **For each item,** include the type of expense, the date, the amount incurred/paid, and to whom. Please attach a copy of the Explanation of Benefits, copies of paid receipts, itemized invoices, cumulative billing statements, or other documents indicating the date of service and/or payment for each expense. You may be able to find the Explanation of Benefits, history of service, claims, prescriptions, etc. on your insurance provider's website.

Name of person receiving treatment: ____________________________ Relationship to student: ___________________

Name of Provider	Date Incurred and/or Paid	Type of Service	Amount Paid by You

1. Are these one-time costs or on-going expenses? ❑ One-time costs ❑ On-going expenses
2. If you have a payment plan set up with your healthcare provider, please provide a copy of your payment plan agreement and include documentation of payment dates and amounts you have paid.
3. Are you reimbursed for these costs by any other agency (DHS, Voc Rehab, other insurance, etc.)? ❑ Yes ❑ No
   If yes, amount received: $________________ From:____

*******OVER*******

Prescription Expenses

Name of person receiving medication: ______________________________ Relationship to student: ________________

Name of Medication	Frequency of Refills	Out-of-Pocket Patient Responsibility

1. Are these one-time costs or on-going expenses? ❑ One-time costs ❑ On-going expenses
   If one-time, provide a copy of a paid receipt or printout from the pharmacy verifying this cost.
   If on-going, provide a printout from the pharmacy verifying these costs.
2. Are you reimbursed for these costs by any other agency (DHS, Voc Rehab, other insurance, etc.)? ❑ Yes ❑ No
   If yes, amount received: $________________ From:____

* *

I certify that the information provided on this form is correct.

____ ___________________________________

Student's Signature Date