

2011-2012 Student Request for Medical/Dental/Nursing Home Expense Adjustment

This form must be submitted by May 1, 2012 to be considered for the 2011-2012 academic year

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 _____

If you have incurred medical/dental/nursing home expenses that you would like us to review for an increase in your cost of attendance, follow the instructions below. **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.

We can only consider medical/dental/nursing home expenses that were paid in 2010. Expenses paid by pre-tax income through a health care spending account cannot be considered.

For returning students, we will consider expenses incurred and/or paid June 2011 through May 2012. **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 2012.

Please attach a copy of Schedule A from your 2010 federal income tax return that identifies the medical/dental/nursing home expenses itemized in 2010. If expenses were not itemized on your tax return, please see instructions below.

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