LBD

Reimbursement Claim Form

Risk Management Office
1628 19th
Lubbock TX 79401

($2,500 Maximum Annual Reimbursement/$100 per office visit limit)

COMPLETE THE PERSONAL INFORMATION SECTION:

Name of Employee	**Date of Birth**	**Employee ID Number**
Name of Claimant IF DIFFERENT from Employee:	**Claimant Date of Birth IF DIFFERENT from above:**	
Employee's Address (NO. STREET, CITY, STATE, ZIP)		
Preferred Contact Info: Phone Number *OR* Email Address	**Campus/Location of Employee**	
Is there a BLOOD SUGAR MONITOR in use? ☐ **Yes** **No** ☐	**Was the monitor from LIVONGO *or* your PHYSICIAN?**	

******* Attach an Insurance Explanation of Benefits for ALL submitted Physician visits. *******

COMPLETE OFFICE VISIT & PRESCRIPTION/SUPPLY SECTION:

(List Date of Office Visit OR Prescription/Supplies Filled Below)	**(Physician Name OR Prescription/Supply)**

AUTHORIZATION: THE ABOVE ANSWERS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE ANY PHYSICIAN, SURGEON, PRACTITIONER OR OTHER PERSON, AND HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITALS, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION, OR ORGANIZATION, TO RELEASE TO EACH OTHER ANY MEDICAL OR OTHER INFORMATION ACQUIRED, INCLUDING BENEFITS PAID OR PAYABLE, CONCERNING THIS OR OTHER DISABILITIES. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL AND DELIBERATE MISREPRESENTATION OR FRAUD BY THE INSURED OR ON BEHALF OF THE INSURED SHALL RENDER VOID ANY AND ALL POLICIES AND/OR CERTIFICATES ISSUED BY THE LUBBOCK I.S.D. OR THEIR THIRD PARTY REPRESENTATIVE.

Employee's Signature _____ **Date** _____

For Office Use Only: (CHECKLIST/PAYMENT PROCESSING)

753.00.6497.DZ.000.00.0.00

Receipts showing payment attached? ☐ Total Reimbursement $_____

Required monthly class/video? ☐

Date payment processed _____

Invoice number_____

Verification Signature: _____ Date: _____

Prepared By: _____ Date: _____

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Reimbursement Claim Guidelines

Reimbursement Overview: Up to $2,500 annually for the following expenses:

- Prescribed drugs for diabetes
- Lancets & syringes at no cost;
- Insulin pumps, strips and associated sets
- Up to $100 for each diabetes related or required doctor visit

(Endocrinology, podiatry, ophthalmology, or associated medical provider)

For questions regarding the LISD Living Better Diabetes Wellness Program, please call:

Sharon Grant, Wellness Coordinator: 806-765-7265

For questions regarding the status of a reimbursement claim, please call:

Vaun Murphrey, LISD Benefits Specialist: 806-219-0283