



WORKERS' COMPENSATION INSURANCE
EMPLOYEE REQUEST FOR REIMBURSEMENT OF MEDICAL EXPENSES

I am requesting reimbursement for medical expenses incurred due to my on-the-job injury. I understand that I must include copies of prescriptions and receipts for reimbursement of medical expenses to be considered for payment.

Employee Name: _____

Date of Injury: _____ Claim Number: _____

Mailing Address: _____
Street
City State Zip Code

Home Phone: _____ Work Phone: _____

Description of medical expense reimbursement request: _____

✓ Total number of enclosed prescriptions: _____
(Note: the perforated piece from the pharmacy prescription information sheet is usually acceptable, however, if an over-the-counter medication was prescribed, a copy of the original hand-written script is required for reimbursement to be considered)

✓ Total number of enclosed receipts (originals required): _____

✓ Total amount of request: _____

Employee Signature: _____ Date: _____

Mail to:
The University of Texas System
220 W. 7th Street
Austin, TX 78701
Phone: 1-888-396-6844