STATE OF ALABAMA

Public Education Employee Injury Compensation Board (PEEICB)

COPAY & DEDUCTIBLE REIMBURSEMENT REQUEST

SUBMIT COMPLETED FORM TO:

Millennium Risk Managers
c/o PEEICB
P.O. Box 382408
Birmingham, AL 35238
Email to: PEEICB@mrm-llc.com
Fax: 205-777-6097

Health Insurance Coverage: ☐ PEEHIP ☐ VIVA ☐ Other

EMPLOYEE INFORMATION			EMPLOYER / SCHOOL INFORMATION
EMPLOYEE NAME:			School System/ Employer:
SSN / Employee ID			School / Location:
Mailing Address:			Department/School:
City:	State:	Zip:	Supervisor Name:
Phone Number:	Email:		Supervisor Phone:

INJURY / CLAIM INFORMATION	
Date of injury: Claim Number:	Have you received payment for this claim from any other source? ☐Yes ☐No If yes, please explain:

COPAY & DEDUCTIBLE REIMBURSEMENT EXPENSES

DATE OF SERVICE (mm/dd/yyyy)	MEDICAL PROVIDER / FACILITY (Doctor, Hospital, Clinic, Therapy, Pharmacy)	PURPOSE OF VISIT	COPAY/ DEDUCTIBLE
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

REQUIRED DOCUMENTATION:
Please submit receipt of copay or paid deductible.

REIMBURSEMENT CALCULATIONS
A. Total Copay Expenses: _____
B. Total Deductible Expenses: _____
C. Total Reimbursement Request (A+B) _____

I certify that the information provided above is true and correct and that these expenses were incurred as a result of treatment for my compensable injury. I have not been reimbursed for these expenses from any other source.

Employee Signature: _____ Date: _____

FOR OFFICE USE ONLY		
Date Received:	Claim Number:	Amount Approved:
Reviewed By:	Check Number:	Date Paid:
Comments:		Initials: