Adoption Reimbursement Request

Employee Information (Please Print)		
Name-First	Last	Daytime Phone Number
Title	Cost Center	FTE

Child's Information (Please attach proof of adoption)	
Child's Name	Date Of Birth
Date Of Adoption	Is This Child In Your Home?

Expense Information (Please attach copies of receipts for the expenses listed)			
Paid To	Services Rendered	Date	Amount

Signature
I have read, understand, and agree to the provisions set forth in the Adoption Assistance policy. I have attached all applicable documentation for reimbursement under the Prevea Health Adoption Assistance policy. I certify that all statements and documentation relating to this request are complete and true to the best of my knowledge. I understand that incomplete or inaccurate information may adversely affect my eligibility under this policy up to and including repayment to Prevea Health of any funds awarded.
Employee Signature Date HR Use Only: Date Authorized by the Chief Medical Officer and/Service Line Director:

If you have any questions, please contact Brenda Kielman at 405-1460/internally extension 71460.

Please return this form and documentation to: Brenda Kielman, Executive Administration – Hansen Site