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Sample Participant Check Request

Instructions: 1. Participant completes information and signs at bottom.
2. Attach receipt or bank statement to receive reimbursement.
3. The amount should not exceed $300.

Medicaid ID#: XXXXXXXXXX

Date of Purchase or Service End Date: MM/DD/YYYY

Pay For
Print Participant Name: John Doe

Phone Number: XXX-XXX-XXXX

Pay To
Print Vendor or Participant Name: John Doe

Address (if vendor): _____

_____

Description of Purchased Goods or Services: Medical Supplies Service Code: T5999

Unit Type: Each (each, hour, date, etc.)

Unit Rate: $ 20

# of Units: 3

Amount: $ 60

Mail to: X Participant _____ Vendor

Approved: John Doe Date: MM/DD/YYYY
Participant or Guardian Signature

iLIFE
Harry and Jeanette Weinberg Building ● 2020 West Wells Street, Milwaukee, WI 53233 ● Phone: 1-888-800-5599
Fax: 414-937-2034 ● Email: IRIS.Claims@mcfi.net ● Website: www.mcfi-fiscalagent.com