|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| UCare Member ID | Member Name (First and Last) | Session Name | SessionDate | TotalSession Fee | Invoice Amount($15 max) | **UCare use only**(eligibility check) |
|       |       |       |       |       | $     .00 | YES: [ ]  Termed: [ ] Ineligible: [ ]  |
|       |       |       |       |       | $     .00 | YES: [ ]  Termed: [ ] Ineligible: [ ]  |
|       |       |       |       |       | $     .00 | YES: [ ]  Termed: [ ] Ineligible: [ ]  |
|       |       |       |       |       | $     .00 | YES: [ ]  Termed: [ ] Ineligible: [ ]  |
|       |       |       |       |       | $     .00 | YES: [ ]  Termed: [ ] Ineligible: [ ]  |
|       |       |       |       |       | $     .00 | YES: [ ]  Termed: [ ] Ineligible: [ ]  |
|       |       |       |       |       | $     .00 | YES: [ ]  Termed: [ ] Ineligible: [ ]  |
|       |       |       |       |       | $     .00 | YES: [ ]  Termed: [ ] Ineligible: [ ]  |
|       |       |       |       |       | $     .00 | YES: [ ]  Termed: [ ] Ineligible: [ ]  |
|       |       |       |       |       | $     .00 | YES: [ ]  Termed: [ ] Ineligible: [ ]  |
|  |  |  | Total Amount Requested: | $     .00 | Amount Reimbursed:  |
|  |  |

School District Name:       District Number:

Make Check Payable To:       Address, City, State, Zip:

Form Completed By:       Phone Number:      Email: