Non-Payroll Reimbursement Request Form

Check Payable to:*_____

Address:*_____

Participant Name: *_____Social Security #:_____/_____/ _____

Did the participant have a hospital or nursing home stay during any of these dates? Yes ☐ No ☐
If YES, please indicate the dates the participant was admitted to and discharged from the Hospital:

Date*	Indicate if Service, Goods or Cash* (please attach receipts, invoices, order forms)	Cash ✓ if yes	Amount to be Paid*

In the event that the total expenses exceed my approved allocation or savings, I understand that ARIS Solutions will not make full payment on my request.

Vendor Signature:_____ Date:_____
*Participant Signature: _____ Date: _____

Payment requests must be submitted every two weeks according to the pay schedule.

Send to:
ARIS Solutions
P.O. Box 4409
White River Jct., Vermont 05001

QUESTIONS?
Phone:1-800-798-1658
Fax:1-802-295-9812
Email: enrollment@arissolutions.org