Participant Name	Employer Name	Employee Name

KS WORK UnitedHealthcare Fiscal Management
Provider Reimbursement Form

IMPORTANT INFORMATION

1. Complete this form to be reimbursed only if one or more of the allowable expenses is in your approved budget.
2. You must document the date of expense and the amount requested for reimbursement.
3. You **MUST** submit a receipt with submission of this reimbursement form. You will not be reimbursed if a receipt is not submitted.
4. Reimbursements **MUST** be submitted within 30 days of the month of service.
5. Send the form with a receipt to: Fax: 1-855-344-5443, Email: pplks-unitedhealthcare@pcgus.com, or mail: Public Partnerships LLC (ATTN: KS WORK UHC), One Cabot Road, Suite 102, Medford, MA 02155.

FOR FASTEST PROCESSING, EMAIL OR FAX DOCUMENTS

Participant Name:	Participant PPL ID:

Date of Expense	Reimbursable Expense	Requested Reimbursement Amount
	Home appliance (APPLIANCE)	$
	Advertising (COAD)	$
	Housekeeping service (HOUSEKEEP)	$
	Laundry service (LAUNDRY)	$
	Meal service (MEALS)	$
	Emergency monitoring Installation (MONITOR)	$
	Emergency monitoring (MONITORINS)	$
	Snow removal service or Mowing (SNOWMOW)	$
	Transportation service (TRANSPORT)	$
	Other (OTHER)	$

Participant Signature:	Date: