DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-02463 (01/2021)

STATE OF WISCONSIN
Tuberculosis Program

TUBERCULOSIS (TB) TREATMENT ASSISTANCE PROGRAM - REQUEST FOR REIMBURSEMENT

Agency Name	Contact Name
Contact Email	Contact Phone

Agency Address (where reimbursement will be sent)

Item No.	Date of Purchase	Quantity and Description of Items Purchased	Patient - Name	WEDSS ID	Purchaser	Cost	Approved or Denied
Example	1/24/19	Fruit cups- 1 case	Last, First	9999999	John Smith	$5.00	
1							
2							
3							
4							
5							
6							
7							
					Total Amount Requested:	$ 0.00	

For Internal Use – Invoice Number:	**TOTAL AMOUNT APPROVED:**	
	Payment Terms: ☐ **Net 30 Days** ☐ **Net 0 Days**	

☐ By **typing my name below,** I certify to the best of my knowledge and belief that the report is true, complete and accurate, and the expenditures are for the purposes, and objectives set forth in the Wisconsin Tuberculosis (TB) Treatment Assistance Program Policies and Procedures Manual.

Return form to:
Wisconsin TB Treatment Assistance Program
Wisconsin Division of Public Health, Tuberculosis Program
Phone: 608-261-6319
Fax: 608-266-0049

Email: DHSWITBProgram@dhs.wisconsin.gov

SIGNATURE – Contact Date Signed

Type full name of Contact (do not use electronic signature)

Clear / Reset Entire form