Budget Appeal - Medical/Dental Documentation Form

Student's Last Name (print) ______________________ Student's First Name (print) ______________________ Date ____________

Student's SAIC ID Number ______________________ Student's Date of Birth ______________________

Use this form to list the medical/dental expenses paid out of pocket and not coved by your health insurance provider.

Attach a copy of your documentation to this form:
Photocopy this form if you need additional lines to document expenses.

	Date Paid	Amount Paid	Identify and attach documentation of payments made. *Copy of bill, receipt, check, payment plan, etc.*
1		$	
2		$	
3		$	
4		$	
5		$	
6		$	
7		$	
8		$	
9		$	
10		$	
11		$	
12		$	
13		$	
14		$	
15		$	
16		$	
17		$	
18		$	
19		$	
20		$	
➡	**GRAND TOTAL =**	**$**	**Amount paid out of pocket as of: ______/______/ 20_____**

I declare, under penalty of perjury, that the information on this form is true, complete and accurate to the best of my knowledge. I understand that if my situation above changes, I must notify the Office of Student Financial Services immediately.

Student Signature ______________________ Date __________ Parent/Spouse Signature (if applicable) ______________________ Date __________