Children's Eye Foundation of aapos
ALL CHILDREN SEE

All Children See Reimbursement Request Form

Practice Name: _____

Physician Name: _____

Email: _____

Phone Number: _____

Mailing Address: _____

Patient Information

Patient Initials: _____

Date of Appointment: _____

Was this patient seen through the All Children See program? Yes ☐ No ☐

Proof of ACS appointment attached (e.g., appointment confirmation): Yes ☐

Reimbursement Request Details

Item(s) Requested for Reimbursement:

_____

_____

Brief Description of Patient Need and Item Provided:

_____

_____

Total Amount Requested: $_____

Itemized Receipts or Invoices Attached: Yes ☐

Payment Method

Reimbursement to provider (receipts must be attached) ☐

Direct payment to third-party vendor (include invoice or bill) ☐

Vendor Name (if applicable): _____

Vendor Address: _____

Certification

I certify that the information provided in this request is accurate and that the expenses submitted are eligible under the ACS Grant Reimbursement Policy.

Signature: _____ Date: _____

Submission Instructions

Please submit this form along with all required documentation to:
Beth Noffsinger – All Children See Program
Email: infocef@aapos.org

Requests must be submitted within 60 days of the expense.
Decisions will be made within 10 business days of receiving a completed request.