Medical Expenses Reimbursement Form

Please return this form along with proof of purchase to Employers Mutual SA
• GPO Box 2575, Adelaide, SA, 5000 • workerreimbursement@eml.rtwsa.com

Name_____

Claim number _____

Reimbursement payed to _____

Reimbursement Type *(please tick one)*

Pharmacy [1]

Medical (including expenses and/or services)

(Any expenses relating to travel need to be submitted using the **EML Travel Reimbursement** form)

Date	**Description** (including dosage for pharmacy items)	**Prescription** (Y/N)	**Purpose for Medication**	**Total Cost** (including discounts)
12-Jan-17	e.g. Panadol Osteo – Paracetamol 665mg – Pack of 100	N	Headaches	$ 5.00
		TOTAL		

[1] If this reimbursement relates to a pharmacy item, please include the script number

I declare that I have paid for this service/item(s) and that the details of this form are true and correct and are relating to my compensable disability.

Signed

Date

We help people get their lives back.