



OVER THE COUNTER DRUG CLAIM FORM

STATE OF WYOMING FLEXIBLE BENEFIT PLAN

2001 Capitol Avenue – Room 106

Cheyenne, WY 82002

Agency Name _____ Agency # _____ Social Security Number _____

Last Name, First Name _____ Home Address _____

City _____ State _____ Zip Code _____

Reimbursement for Over-The-Counter Drugs for the Month of _____
This section must be completed in its entirety.

Name of Drug	Date of Purchase	Patient			Requested Amount
		Name	Relationship	Age	
1.					\$
2.					\$
3.					\$
4.					\$
5.					\$

Total Reimbursement Requested \$ _____

- ✓ You must attach an itemized store receipt for each drug purchased or if the drug name is not listed on the receipt, your pharmacist will need to sign the receipt with the name of the drug and their signature.
- ✓ You may only claim a total of \$50.00 per month for over-the-counter drugs. You will have to complete a claim form for each month you have allowable expenses.

I request reimbursement from the Employee Reimbursement Account(s) for the expenses itemized above. I hereby certify that I have read and understand the guidelines on this form and that these expenses must qualify for reimbursement under the Internal Revenue Code as outlined on the form.

I further certify that these expenses are not eligible for reimbursement from any other source. I also understand that reimbursement expenses cannot be claimed as credits or deductions on my personal tax return.

Employee's ****original** Signature

Date

****This form requires an original signature and will not be processed if the signature is a copy.**

Submit Claims to:

Department of Administration & Information

Human Resources / Employee Benefits

Attn: Cafeteria Plan Section

(307) 777-6835

FOR OFFICE USE ONLY

Date Received

Date Paid