(BUDMED) Budget Adjustment Medical/Dental Addendum

2024-2025

University of South Florida
Office of Financial Aid • 4202 East Fowler Avenue, SVC 1102 • Tampa, Florida 33620-6960

Student's Name: _____ USF ID: U ____ ____ ____ ____ ____ ____ ____ ____

- This form, along with any attachments, must be completed and submitted to OFI no later than the date indicated on the budget adjustment request form.
- Insurance premiums are not considered a medical/dental expense for the purpose of this form.
- Over-the-counter medications and/or elective/cosmetic procedures cannot be included.
- Only copies of documents should be submitted. Keep any originals for your own records, as they cannot be returned.
- Expenses can only be for independent student named above only. Spouse and dependent expenses CANNOT be included.

Instructions:

- Any additional sheets needed for expenses should match formatting of table below and attached to this form.
- Attach copies of receipts for paid bills. The following documents are not acceptable:
  - Explanation of benefits letters
  - Cancelled checks
  - Self-written verification of payments
  - If insurance paid bill or reimbursed you, it will not be accepted.
- For each receipt:
  - Write number on top right corner of receipt.
    - This number should also be written on table in "Receipt Number" box.
  - Circle the paid amount and the date on the receipt or documentation.
    - Use black ink only. Do not use highlighters.
    - Write date in date box in row that matches receipt number.
    - Write total bill amount and the amount you paid (but were not reimbursed) in appropriate box.
  - Write name of doctor/hospital in box that matches receipt number.
    - If name is not apparent on bill, documentation must be provided alongside (which includes information showing corresponding bill)
- If treatment received can be considered elective/cosmetic, a statement explaining medical necessity must be submitted.
- The back of this document must be signed.

MEDICAL EXPENSES MUST HAVE OCCURRED DURING CURRENT ACADEMIC YEAR AND PERIODS OF ACTIVE ENROLLMENT

Medical/Dental Expenses (attach copies of bills and proof of payment)

Receipt Number	Date DD/MM/YYYY	Illness/Injury (Reason for visit)	Doctor/ Hospital	Total Bill Amount	Amount I/We Paid

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Receipt Number	Date DD/MM/YYYY	Illness/Injury (Reason for visit)	Doctor/ Hospital	Total Bill Amount	Amount I/We Paid

TOTAL PAID:

Student Certification:
I affirm that:

- All the information provided in this request is true and accurate to the best of my knowledge.
- The penalty for giving false information may include repaying any funds received.
- Turning in this form does not guarantee the request will be approved.
- Any decision based on this request cannot be appealed to the Department of Education.

Student (Required) _____ _____ ____/____/____
Print Name **Signature** **Date**