ARCHDIOCESE OF NEW ORLEANS

CLERGY MEDICAL REIMBURSEMENT FORM

Submission Date:

Name:

***Priest Status:**

Mailing Address:

City, State, Zip:

Expense Detail (Listed by Individual Receipts with Support Attached):

**Type	Invoice Date	Vendor/ Provider	Reimbursement Amount

Grand Total: $ 0.00

Submission Signatures:

Priest

ANO Benefits Office

*Status should be either Active or Retired
**Type of expense should be: Medical Co-Pays, Prescription, Dental, Vision, Miscellaneous

Priest Benefit Review Committee (if required)