

CLAIM FORM

CHERRY VALLEY – SPRINGFIELD CENTRAL SCHOOL
 PO BOX 485
 CHERRY VALLEY, NEW YORK 13320
 607-264-3257 EXT 510

TO BE COMPLETED IN BY VENDOR

(please print)

Name of Vendor _____

Social Security Number _____

Or

Employee ID Number _____

No payment will be made without one of the above numbers!!!!

Telephone: _____ Date: _____

Qty	Unit	Medicare Reimbursement for 2023	Price	Total
1	Year	I am a : Faculty Retiree _____ Faculty Spouse _____		
1	Year	I am a: Support Staff Retiree _____ Support Staff Spouse _____ As a retiree of the Support Staff I understand that my reimbursement is capped at <u>\$1250.00</u> for both myself and my spouse.	\$1250.00	\$1250.00

PLEASE INCLUDE A COPY OF YOUR
SSA-1099 SOCIAL SECURITY BENEFIT STATEMENT
 AND A COPY OF YOUR MEDICARE CARD.

FORMS DUE NO LATER THAN March 1, 2024

Invoice Total: _____

This is to certify that the materials and services charged in the above account or claim and included in the same, have been actually furnished, delivered or performed to the Cherry Valley – Springfield Central School District, Cherry Valley, NY; that said claim is just, due and unpaid and that there are no offsets against the same; that the items and specifications are correct; that the sums charged are reasonable and just; that no New York State Sales Tax has been included; that no payment has been made on account thereof, except as included or referred to in such account or claim. If this claim is for mileage or reimbursement for expenses, then documentation of prior approval is attached. Examples of prior approved are conference request form, requisitions or purchase orders.

Vendors Signature

Date

Supervisor

Business Office

Purchasing Agent

Claims Auditor