# 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 2024 | Price | Total |
|---|---|---|---|---|
| **1** | **Year** | I am a :<br>Faculty Retiree_____ Faculty Spouse____ | | |
| **1** | **Year** | I am a:<br>Support Staff Retiree____ Support Staff Spouse____<br><br>As a retiree of the Support Staff<br>I understand that my reimbursement is<br>capped at $1250.00 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, 2025*

**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 |