



VFW Department of California

1510 "J" Street, Suite 110

Sacramento, Ca 95814

Phone: (916) 449-8850 Fax: (916) 449-8832

BLOOD ASSISTANCE REQUEST FOR REIMBURSEMENT

The Department of California VFW will reimburse the cost for not more than ten (10) units of blood per year if the cost had to be paid by the member after all insurance coverages have been exhausted. This form must be completed in its entirety and have the invoice or receipt attached. After completion mail this form to Department Headquarters chairman. No reimbursement shall be made unless the member is considered in good standing.

I hereby request reimbursement in the amount of \$ _____ for blood replacement which is not covered by my private insurance carrier.

Date _____

Name of Recipient _____

Mailing Address _____

Phone Number _____

Post No/District No. _____

Membership No. _____

The Post Quartermaster must verify membership status. The above recipient is a member in good standing as of the date of this request.

Commander/Quartermaster Signature

I have reviewed the above request and recommend payment in the amount indicated.

Date:

Signature