

## Request for Infertility Treatment Reimbursement

Employee Name: \_\_\_\_\_

Employee's Department: \_\_\_\_\_

Dartmouth ID: \_\_\_\_\_

Date of Service	Description of Treatment/Service

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Attach copies of all receipts to this completed form and deliver to:**

**Ashley Buck, Health Benefits Administrator, at 7 Lebanon Street, Suite 203,  
Hanover, NH 03755-2112, or via Hinman mail at HB 6042.**