Last Name, First Name

NAME:

Return to:

Raytheon Polar Services Company / ATTN: Finance
7400 S. Tucson Way, Centennial CO 80112-3938
Telephone: (303) 790-8606 (800) 688-8606 Fax: (720) 895-0424

Date Stamp / Received

MEDICAL/DENTAL EXPENSE REIMBURSEMENT FORM

RPSC is authorized to reimburse qualified USAP participants for out-of-pocket fees or approved medical and dental costs incurred while obtaining clearance for deployment to Antarctica. All candidates are responsible for submitting the proper claims to their insurance carrier and for paying any fees/deductibles associated with the medical and dental clearances directly to their provider. The reimbursement amount will be the amount of the cost minus any insurance payment or discount. Please wait to submit your reimbursement until you have the final claims from your insurance carrier showing the balance due. You must pay this balance due in full before you can be reimbursed. RPSC is authorized to reimburse for dental exams and x-rays, but is **not authorized to reimburse for cleanings (prophylaxis) or work done on teeth**. RPSC is authorized to reimburse up to $175.00 for one pair of prescription sunglasses and also up to $175 for one pair of prescription safety glasses (if required for job duties) (frames plus lenses) **every other year.** RPSC is not authorized to reimburse for eye exams or non-prescription sunglasses. RPSC is only authorized to reimburse for prescription sunglasses/safety glasses after you are medically and dentally cleared for deployment and detailed receipts are attached. **Falsifying and/or fraudulent claims may result in penalties and disqualification from the United States Antarctic Program.**

USAP participants should complete and submit this form along with *ITEMIZED BILLS* showing full payment from the doctor/dentist/optometrist and any corresponding insurance provider information.

Medical	Amount	Dental	Amount
Physical Exam (Including EKG – 12 Lead)		Dental Examination	
Labs (required)		Bitewing X-rays	
Immunizations (Tetanus, Flu, etc.)		Panographic or Full Mouth X-Rays	
Tuberculin Skin Test - PPD		PA X-ray(s)	
Exercise Stress Test & Read			
HIV Test		**DENTAL TOTAL**	
Chest X-ray			
Mammogram			
GYN Exam (w/ Pap Smear)		**Rx Sunglasses / Safety Glasses**	**Amount**
Drug Screen			
Gallbladder U.S.		Rx Sunglasses – Frames + Lenses	
EKG / ECG			
Audiology / Hearing Test		Rx Safety Glasses – Frames + Lenses	
Pulmonary Function Test (Spirometry)			
Medical Misc. (list):			
MEDICAL TOTAL		**Rx Sunglasses/Safety Glasses TOTAL**	

MAILING ADDRESS to send check: ______________________________

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SIGNATURE (Required): ______________________________

For RPSC use only:	**Amount**	**Approver**	**Date**
Total Reimbursement Due to Participant:			

Distribution	**Amount**	**WBS Charge Code:**	**GLA:**
> Medical	**$**	**R-PS___0-210A40___03BA**	**521099**
> Dental	**$**	**R-PS___0-210A40___03BA**	**521099**
> Rx Sun/Safety Glasses	**$**	**R-PS___0-210A40___03BD**	**521099**