**Department of Health Services**
Division Of Public Health
F-02463 (03/2025)

**State of Wisconsin**
Tuberculosis Program

# Tuberculosis (TB) Treatment Assistance Program - Request for Reimbursement

| Agency name | Contact name |
|---|---|
| Contact email | Contact phone |

Agency address (where reimbursement will be sent)

| Item number | Date of purchase | Quantity and description of items purchased | Patient - Name | WEDSS ID | Purchaser | Cost (Receipt required) | Approved or denied |
|---|---|---|---|---|---|---|---|
| Example | 1/24/19 | Fruit cups- 1 case | Last, First | 9999999 | John Smith | $5.00 | |
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
| | | | | | Total amount requested: | $ 0.00 | |

| **For internal use – invoice number:** | **Total amount approved:** | |
|---|---|---|
| | **Payment Terms:** ☐ **Net 30 Days** ☐ **Net 0 Days** | |

☐ By typing my name below, I certify to the best of my knowledge and belief that the report is true, complete and accurate, and the expenditures are for the purposes, and objectives set forth in the Wisconsin Tuberculosis (TB) Treatment Assistance Program Policies and Procedures Manual.

**Signature** – Contact Date signed

Type full name of Contact (do not use electronic signature)

**Return form to:**
Wisconsin TB Treatment Assistance Program
Wisconsin Division of Public Health, Tuberculosis Program
Phone: 608-261-6319
Fax: 608-266-0049

Email: DHSWITBProgram@dhs.wisconsin.gov

Clear/reset entire form