**Budget Appeal
Affidavit – Medical, Dental or Optical Expenses**

|  |
| --- |
| 1. **Student Information**
 |
| **Student Name:** |  | **7-digit NAU ID Number:** |  |
| **Phone:** |  | **NAU Email:** |  |
| **B. Expenses Related to Out of Pocket Costs for the Student’s Medical, Dental or Optical Expenses**Provide copies of Itemized receipts, in the student’s name, listing expenses incurred, expense amount, paid amount, date paid and must be on business letterhead or invoice. Only expenses not covered by insurance, health savings plans or other parties can be considered. Only the student’s portion of these expenses can be considered. |
| **Detailed Description of Expense** | **Medical / Dental / Optical Provider Name** | **Date Paid** | **Amount Paid** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Total Amount of Expenses Paid** |  |
| **C. Medical, Dental or Optical Insurance**Provide copies of Itemized receipts and insurance billing statements in the student’s name, listing expenses incurred, expense amount, paid amount, date paid and must be on business letterhead or invoice. Only the student’s portion of these expenses can be considered. |
| **List the type of Expense (Medical, Dental or Optical)** | **Insurance Provider Name** | **Amount Paid Per Month** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **D. Agreement and Understanding** |
| By signing below, I acknowledge that I have read and understood all the information outlined in this form. I attest that all information that I am providing is true and accurate. I acknowledge that I understand that only expenses incurred by me, as the student, are considered for the appeal process. **Signature must be hand-written, typed or electronic signatures will not be accepted.** |
| **Typed – Student First and Last Name** |  |
| **Student Signature** |  |
| **Date** |  |