MTA/CTA Reimbursement Claim Details [Complete the top section and the red columns below only]

Church/Organization:		Church/Organization ID #: C	
MEMBER NAME:		Trip #: T	
Member Number:		Member State of Residence: →	
Registered Date		Cancellation Effective Date:	
Destination City:		Type(s) of Claim - Mark "X" Below	
Destination Country:		Medical Cost	
Travel Dates Departure:		Travel Cost	
Travel Dates Return:		Luggage Cost	
Optional Cancellation & Interruption Added - YES or NO →		Other Cost	
Claim Payable To:			
Attention (optional):		City:	
Address Line 1:		State:	
Address Line 2:		Zipcode:	
Please list Your USA MEDICAL INSURANCE COVERAGE (example: Medicare, Blue Cross/Blue Shield, etc...) → → → → →			

Please complete: Date of Service // Memo // Original Cost // Country Currency

Item	Date of Service	Memo: Service Provider (When claim is for more than one member please list names & member numbers below)	Original Cost	Receipt Received X	Country Currency Code	Country Exchange Rate	USD Amount	USD amount Approved
1							$ 0.00	
2							$ 0.00	
3							$ 0.00	
4							$ 0.00	
5							$ 0.00	
6							$ 0.00	
7							$ 0.00	
8							$ 0.00	
9							$ 0.00	
10							$ 0.00	
11							$ 0.00	
12							$ 0.00	
13							$ 0.00	
14							$ 0.00	
15							$ 0.00	
16							$ 0.00	
17							$ 0.00	
18							$ 0.00	
19							$ 0.00	
20							$ 0.00	
21							$ 0.00	
22							$ 0.00	
23							$ 0.00	
24							$ 0.00	
25							$ 0.00	
If more item lines are needed, please complete another form				CLAIM TOTAL USD BALANCE			$ 0.00	
Please Give a Brief Explanation for Your Claim Below				Total USD APPROVED Claim Reimbursement				$ 0.00

Claim Explanation: