

Last Name, \_\_\_\_\_

First Name \_\_\_\_\_

**NAME:**

Date Stamp / Received

**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

**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. 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		<b>DENTAL TOTAL</b>	
Chest X-ray			
Mammogram			
GYN Exam (w/ Pap Smear)		<b>Rx Sunglasses / Safety Glasses</b>	<b>Amount</b>
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):			
<b>MEDICAL TOTAL</b>		<b>Rx Sunglasses/Safety Glasses TOTAL</b>	

MAILING ADDRESS to send check: \_\_\_\_\_

SIGNATURE (Required): \_\_\_\_\_

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