OSWEGO STATE UNIVERSITY OF NEW YORK

Financial Aid Office – 206 Culkin Hall – Oswego, NY 13126
Phone 315-312-2248 – Fax 315-312-3696 – E-mail financial.aid@oswego.edu

2021/2022 Request for Review due to Medical Expenses

Student Info:

____
Last Name First Name ID#

____
Street City State Zip

____
Phone # Preferred Email

____
Parent(s) Name(s) Phone # Preferred Email

Please complete and return this form **with documentation** (bills, statements, pharmacy reports, etc.) to the Financial Aid Office.

From January 1, 2021 to today, please list any medical and /or dental expenses that were not covered by insurance or other health care benefits. Include any expenses that will not be reimbursed to you, including co-payments to a pharmacy. Please indicate whether a full payment has been made, or if you are making monthly payments to the provider. You may attach additional sheets if necessary.

$_________________Paid to ____

$_________________Paid to ____

$_________________Paid to ____

Do you have a Flex Medical Plan to help cover some of the medical expenses above that are not reimbursed?
______Yes ______No
If so, what amount is contributed to this plan monthly? ________________________
How much has been withdrawn to date this year? _____________________________

I certify the above is true and accurate to the best of my ability at this time. I understand that I may be asked for further information and documentation to support my request for review.

____ _________________________
Signature Date

____
Your relationship to Student