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Uncovered Medical/Dental Expenses Form

Complete this form if you have Medical or Dental Expenses that were NOT covered by insurance. Submit this form along with supporting documentation to the Office of Student Financial Services. The expenses you list below will not be considered unless the form is completed in full. If additional space is needed, please use a copy of this form.

Student Name:		**Fordham ID:**	
Please indicate what type(s) of coverage you have:	Medical ☐ Dental ☐ Vision ☐		

Patient Name	**Provider Name (Dr., Rx., Etc.)**	**Date of Service**	**Total Charges**	**Amount Paid By Insurance or Other Sources**	**Amount Not Covered by Insurance (Paid by Family)**
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			Total Amount of Expenses Covered by Family:		$

Please use a handwritten signature to confirm this statement.

Student's Name (Print)	**Student's signature***	**Date:**
Parent's Name (Print)	**Parent's signature***	**Date:**

***Please note that we do not accept electronic signatures.**