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## Conceptual Options Surrogacy Program PAYMENT/REIMBURSEMENT REQUEST

Conceptual Options' Agency Protocol requires that all Surrogates' shall submit all requests for payment and/or reimbursement for items listed in the surrogacy contract **no later the 15<sup>th</sup> of each month**. Funds are paid out of trust accounts on the **1<sup>st</sup> of every month**, unless your contract stipulates otherwise. ***In the event that requests are not received by the 15<sup>th</sup>, your payment may be delayed.***

Surrogate's Full Name: \_\_\_\_\_

Date of Embryo Transfer (Real or Scheduled): \_\_\_\_\_

If Applicable, Number of Weeks Pregnant on the 1<sup>st</sup> of the Upcoming Month: \_\_\_\_\_

### ITEMS REQUESTED FOR PAYMENT:

Monthly Non-Accountable Expense Allowance: Amount \$ \_\_\_\_\_  
Identify Paragraph/Section in Contract authorizing this payment: \_\_\_\_\_

Monthly Pregnancy Compensation Due: Amount \$ \_\_\_\_\_  
Identify Paragraph/Section in Contract authorizing this payment: \_\_\_\_\_

Monthly Twin/Triplet Compensation Due: Amount \$ \_\_\_\_\_  
Identify Paragraph/Section in Contract authorizing this payment: \_\_\_\_\_

Mileage Reimbursement (round trip): \_\_\_\_\_ miles – \_\_\_ miles base = \_\_\_\_\_  
miles X .\_\_ a mile = (total) \$ \_\_\_\_\_  
o Date(s) and purpose for mileage reimbursement requested:  
\_\_\_\_\_

Identify Paragraph/Section in Contract authorizing this payment: \_\_\_\_\_

**Attach Mapquest printout of trip mileage to this request.**

Childcare Reimbursement \$ \_\_\_\_\_ **Attached receipt required**  
o Date(s) and purpose for childcare reimbursement requested:  
\_\_\_\_\_

Identify Paragraph/Section in Contract authorizing this payment: \_\_\_\_\_

Monthly Counseling Appointment Amount \$ \_\_\_\_\_ Date(s): \_\_\_\_\_  
Identify Paragraph/Section in Contract authorizing this payment: \_\_\_\_\_

RX Reimbursement: Amount \$ \_\_\_\_\_ Date(s): \_\_\_\_\_ **Attach Receipt**  
Identify Paragraph/Section in Contract authorizing this payment: \_\_\_\_\_

Maternity Clothing Allowance Due: \$ \_\_\_\_\_ Current # Wks. Pregnant \_\_\_\_\_  
Identify Paragraph/Section in Contract authorizing this payment: \_\_\_\_\_

**Conceptual Options Surrogacy Program**  
**PAYMENT/REIMBURSEMENT REQUEST**

Lost Wages: Reason: \_\_\_\_\_

○ Date(s) being Reimbursed: \_\_\_\_\_

○ Hourly Pay: \_\_\_\_\_ hours X \$ \_\_\_\_\_ per hour = (total) \$ \_\_\_\_\_

\*\*\*Note: Wages are paid at Net only (i.e.; less taxes and deductions)

○ **Attach 3 Most Recent Pay stubs**

○ **Attach Physician note**

Identify Paragraph/Section in Contract authorizing this payment: \_\_\_\_\_

Health Insurance Monthly Premium: Amount \$ \_\_\_\_\_ **Attach Invoice/Paystub**

Identify Paragraph/Section in Contract authorizing this payment: \_\_\_\_\_

Life Insurance Premium: Amount \$ \_\_\_\_\_ **Attach Invoice/Receipt**

Identify Paragraph/Section in Contract authorizing this payment: \_\_\_\_\_

Medical Appt. Deductible/Co-pay: Amount \$ \_\_\_\_\_ **Attach Invoice/Receipt**

Identify Paragraph/Section in Contract authorizing this payment: \_\_\_\_\_

Housekeeping Needed: Reason/Bedrest Dates: \_\_\_\_\_

○ Amount to be Reimbursed for Housekeeping \$ \_\_\_\_\_ **Attach Receipts**

Identify Paragraph/Section in Contract authorizing this payment: \_\_\_\_\_

Other Misc. Reimbursements/Funds Requested:

(Reason): \_\_\_\_\_

\_\_\_\_\_

Amount \$ \_\_\_\_\_ Date(s) of Occurrence: \_\_\_\_\_

Identify Paragraph/Section in Contract authorizing this payment: \_\_\_\_\_

I, \_\_\_\_\_, hereby state that the amounts listed on page one and two of this form are due to me according to the contract I have signed with my Intended Parent(s) and that I will **attach any and all receipts/invoices** pertaining to said fees to this form and that I fully understand that all reimbursements are to be approved prior to release of funds. Any funds that are owed as a result of bedrest, disability or medical condition requires a copy of doctor's note on file. I understand that any missing receipts or late requests may result in a delay or denial of request.

Note that lost wages beyond 7 days requires submission to State Disability/Employment Development Department for benefits request and that reimbursement is for net lost wages not covered by the State. Claim forms are available through your Obstetricians office.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_