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 than 15th of each month**. Funds are paid out of trust accounts on the **1st of every month**, unless your contract stipulates otherwise. In the event that requests are not received by the 15th, your payment may be delayed.

Surrogate's Full Name: ____

Date of Embryo Transfer (Real or Scheduled): ________________________________

If Applicable, Number of Weeks Pregnant on the 1st 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: _____________

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- ❑ 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: _________________

Refer a Friend and receive $250.00,
once she has signed contracts!