Jacksonville Transplant Alliance

Prescription Reimbursement Form

Please complete the following information. Missing information may delay receipt of your reimbursement.

Recipient Name ____ Date _________________

Street Address ____

City _____________________________________ State _________________ Zip ______________

Email ____

Date of Transplant ______________ Transplanted Organ(s) _________________________________

Name of your Transplant Social Worker ____

Medication(s) for Reimbursement ____

Receipt Total $_____________ Name of Pharmacy ____

Location of Pharmacy: City ____ State ______________

Return upper portion of form with receipts to the address below.

Cut here ✂ -

Keep lower portion.

To receive up to a $100 reimbursement on your medications, please mail your completed Prescription Reimbursement Form along with your receipts or pharmacy statements to the address below. Receipts must show the date and the name of the medication(s) for which you are being reimbursed. Only receipts dated after January 1, 2023 will be accepted.

Steven Binder
Jacksonville Transplant Alliance
2060 Hovington Circle East
Jacksonville, FL 32246-1110

If you have any questions, please email Steven Binder at stevenfla@comcast.net.

Reimbursement checks will be mailed approximately 3 weeks following receipt of your form. Checks will be written by and sent from the Nonprofit Center of Northeast Florida.

*Please note: This reimbursement program is available until program funding is exhausted.