MARYLAND WIC PROGRAM
REQUEST FOR REIMBURSEMENT
CHECK EXCEEDING MAXIMUM AMOUNT

TO: DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MARYLAND WIC PROGRAM
201 W. PRESTON ST. – ROOM 104
BALTIMORE, MD 21201

DATE:_____

FROM: _____ & _____ & _____
NAME STORE NAME VENDOR ID#

CHECK # _____ **REQUESTED AMOUNT $**_____

PLEASE ENTER THE INFORMATION BELOW FOR ITEMS THAT HAVE BEEN PURCHASED.

ITEM:	SIZE:	QTY:	PRICE:
BEANS, PEAS OR LENTILS	1LB	_____	$ _____
CEREAL	_____ OZ OR LESS	_____	$_____
GERBER INFANT CEREAL	8 OZ.	_____	$ _____
EGGS	1 DOZEN	_____	$ _____
CARROTS	_____	_____	$_____
CHEESE			
DOMESTIC	_____ OZ OR LESS	_____	$ _____
KOSHER	_____ OZ OR LESS	_____	$ _____
JUICE	_____	_____	$_____
GERBER INFANT JUICE	32 OZ.	_____	$ _____
MILK			
DRY	_____	_____	$ _____
EVAPORATED	12 OZ. CAN	_____	$ _____
FLUID	_____	_____	$ _____
KOSHER	_____	_____	$ _____
LACTOSE REDUCED	_____	_____	$ _____
UHT	_____	_____	$ _____
PEANUT BUTTER	_____ OZ OR LESS	_____	$ _____
TUNA	_____	_____	$_____

FORMULA (ENTER TYPE, SIZE, QUANTITY, AMOUNT)

_____ _____ _____ $_____

GRAND TOTAL $ _____

DHMH 4295-B (5/03)