

FUNERAL DIRECTOR REPORT

Name of Deceased: _____
Name of Claimant: _____
Date of Funeral: _____ Compensation Claim Number: _____

Who signed as responsible for the funeral expenses? _____
Address (if known): _____

In order to make proper reimbursement, please list all sources of payment you have received on this funeral bill (if there are additional payees, please list on the back of this form):

Payment From: _____	Amount: \$ _____
	SSN (if known): _____
Payment From: _____	Amount: \$ _____
	SSN (if known): _____
Payment From: _____	Amount: \$ _____
	SSN (if known): _____
Beginning Balance on Account: \$ _____	
Current Balance on Account: \$ _____	

Funeral Provider Name: _____
Address of Funeral Provider: _____

Signature of Funeral Provider: _____ Date: _____
Federal Tax ID Number: _____

Please Attach a Copy of the Itemized Statement

Return Form To:

DAC
Attn:
421 NW 13TH
Suite 290
Oklahoma City OK, 73103

Phone: 405-264-5006
Fax: 405-264-5097

Attachment (d)