

Name:

Cryo-Cell Client ID#:

Directions: To obtain reimbursement up to \$175, follow these simple steps:

1. Indicate the amount charged by your practice for the cord blood collection.
2. Designate if PRACTICE or PATIENT is to receive the reimbursement check.
3. Provide authorized practice signature, tax ID and date. Please note any correction to practice contact information.
4. Obtain patient signature, date and Cryo-Cell Client ID.
5. Return to Cryo-Cell via fax or mail.

Note: Collection reimbursement will be issued within 10 business days of voucher receipt AND following specimen certification. Collection reimbursement expires 90 days from patient's delivery date.

Return to:

Cryo-Cell International, Inc.
 Attn: Finance
 700 Brooker Creek Blvd.
 Suite 1800
 Oldsmar, FL 34677

Phone: 800-786-7235
 Fax: 800-679-8060

Practice Contact Information:

(please provide any needed corrections)

Please remit to:

[] _____ or to [] _____
Practice Name Client Name & ID#

AMOUNT CHARGED FOR THE COLLECTION PROCEDURE:

\$

Up to \$175 eligible for reimbursement

Signature of Patient Date

Signature of Healthcare Professional or Practice Manager Date

Practice Tax ID#

Collection reimbursement expires 90 days from patient's delivery date. EDC: