**Funeral Home Reimbursement Claim Form**

***This is a confidential report and will be incorporated in the patient’s medical record.***

Name of Deceased\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Death \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Place of death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Autopsy? Internal External None

Type of donor (please check all that apply): Skin Upper Bone Lower Bone Heart

**Please describe the procedures that were required because of donation if not specifically listed on the embalming report. Please also note if the funeral home itself incurred any transportation costs directly related to DNA’s involvement:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Funeral Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address/City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tax ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total dollar amount requested: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I hereby certify that the above work was completed as described. I also certify that I have not charged the family any fees in relation to the donation process****.*

Name of Funeral Director (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Funeral Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax, email or mail to: Tiffany Welton

 Reimbursement Checklist

 Fully completed claim form

 Embalming report

 GPL (if necessary)

 Partner Relations Coordinator

 Donor Network of Arizona

201 W Coolidge St.

Phoenix, AZ 85013

 Office: 602-200-7514

Fax: 602-200-7537

 Email: funeralhomes@dnaz.org

 Funeral Home Questionnaire

**Donor Network of Arizona use only:**

Date received: \_\_\_ \_/\_\_ \_ / \_ \_\_ Case #: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Authorized by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reimbursement date: \_\_ \_ \_/\_\_ \_\_\_/\_\_ \_\_\_

Funeral Home Questionnaire

**Funeral Home Feedback**

We take great pride in the work that we do for our donors, donor families and all of our partner companies.

We would appreciate your feedback to help improve our processes and/or to address any questions or concerns you may have.

To help us better serve you, please complete this survey and return it to Donor Network of Arizona.

Attention: Partner Relations Coordinator, By Mail: 201 W Coolidge St. Phoenix, AZ 85013 Fax: 602-200-7537, Email: funeralhomes@dnaz.org

|  |  |
| --- | --- |
| **Donor Name** |  |
| **Donor Hospital** |  |
| **Date of Donation** |  |
| **Funeral Home** |  |
| 1. DNA makes an effort to contact funeral homes when a family has told us what establishment they will be using. Was your funeral home contacted by DNA prior to recovery?

  |  |
| 1. Were all family requests for viewing/service times able to be met? In what ways could DNA have improved to help meet family viewing/service times?
 |  |
| 1. If upper extremity bone tissue was recovered, were the brachial arteries tagged properly on each arm?
 |  |
| 1. Was the decedent restored and cleaned upon arrival to the funeral home after recovery? In what ways could DNA improve upon the post recovery care of donors?
 |  |
| 1. If the donor was embalmed, was sufficient perfusion able to be obtained? In what ways could DNA improve upon recovery to assist with perfusion during embalming while still procuring the appropriate tissue needed for transplantation?
 |  |
| 1. Please provide any additional comments or suggestions you have that would help DNA to better serve your funeral home.
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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Funeral Director Name and License Number Date