State of Illinois
Department of Human Services

To: ____________________

Vendor Name

____

Street

____

City State Zip Code

SUBMIT TO: Department of Human Services
Funeral/Burial Claims Unit
425 South 4th Street
Springfield, Illinois 62701

Vendor Name: ____________________

____

Vendor Federal Employee's Identification Number

REQUESTS THE FOLLOWING FORMS:

Check:

☐ Form 29 QUANTITY: ____________
FUNERAL OR BURIAL CLAIM

☐ Form 94 QUANTITY: ____________
FUNERAL OR BURIAL REIMBURSEMENT CLAIM

____________________ ____________________

Vendor's Signature Date

FOR AGENCY USE ONLY

____________________ ____________________

Burial Claim Unit Approval Date Approved