PERALTA COMMUNITY COLLEGE DISTRICT HEALTH PLAN REQUEST FORM FOR REIMBURSEMENT

Please use a separate claim for each healthcare professional and for each individual covered. Please provide itemized bill(s) for each claim.

Retiree Information			
Retiree's Full Name	Date of Birth	Retiree's Mailing Address	
Retiree's Current Health Insurance Plan and Level of Coverage	☐ Anthem Medicare Advantage ☐ Kaiser SISC ☐ Anthem Prescription	☐ Traditional Medicare + Supplement ☐ Kaiser SISC Senior Advantage	☐ Kaiser Prescription ☐ SISC PPO ☐ Other _____
Patient Information (Complete only if Patient is not the retiree)			
Patient's Name (First and Last):	Patient's Relationship to Retiree:	Patient's Date of Birth:	Patient's Primary Telephone Number
Patient's Mailing Address:			
Accident or Occupational Claim Information			
Is this claim a result of an accident or illness due to employment?			
Is this claim a result of an injury due to an auto accident?			
Is the retiree or dependent filing a Workers' Compensation claim, insurance claim or lawsuit to cover the costs of this claim? If so, please describe			
Other Coverage Information			
Is the patient covered under another health insurance plan?			
If yes, please provide the type of plan and coverage information.			

If the patient is covered under another health insurance plan, has the retiree or dependent filed a claim for reimbursement of costs under that plan?	

Explanation

Please explain the basis for the claim.

☐ Used to be covered but is not now covered
☐ Provider does not accept Medicare Assignment
☐ Service covered when I retired but is not covered under current plan
Service _____
☐ Drug was/is eligible for contracted co-pay (Amount _____) but pharmacy is charging more
☐ Other (please explain)

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Certification

I certify that the information I have supplied on this form is true and correct. I further certify that reimbursements requested do not include any amounts that have been reimbursed or covered by insurance, a flexible spending account, or other plan

SIGNATURE:	
DATE:	