CCPU HEALTH CARE FUND

Reimbursement Request Form

INSTRUCTIONS

To process your reimbursement request, this form must be fully completed, signed, and returned with all required documents. You must attach a copy of your receipt that shows the dollar amount of your request, when the service occurred, and when it was paid. Please allow up to 30 days for review and processing after you submit your request for reimbursement.

Please submit to:

Mail: CCPU Health Care Fund
P.O. Box 57027
Irvine, CA 92619

Email: reimbursement@ccpuhealth.org

PROVIDER INFORMATION

Name	CCPU Health Care Fund ID	Phone Number

Address

City	State	Postal Code

Is this a new address?

☐ Yes ☐ No

EXPENSE INFORMATION (Please see the back of this form for a description of expense types.)

Type of Expense	Provider's Name	Premium Month / Date of Service	Health Plan Carrier/ Service Provider	Amount
☐ Premium Expenses ☐ Out Of Pocket Medical Expenses ☐ Permissible Expenses (Medi-Cal Only)				
☐ Premium Expenses ☐ Out Of Pocket Medical Expenses ☐ Permissible Expenses (Medi-Cal Only)				
☐ Premium Expenses ☐ Out Of Pocket Medical Expenses ☐ Permissible Expenses (Medi-Cal Only)				
☐ Premium Expenses ☐ Out Of Pocket Medical Expenses ☐ Permissible Expenses (Medi-Cal Only)				
			Total Expenses:	$ 0.00

SIGN AND ACKNOWLEDGE

I attest that the information contained in this Request for Reimbursement is true and accurate. I am an eligible participant in the CCPU Health Care Fund program, enrolled in a qualified health plan, and seeking reimbursement for a medical health care service covered under my qualified health plan. I understand that if I provide incomplete, false or misleading information, my Request for Reimbursement may be delayed or denied. I agree to indemnify and hold the CCPU Health Care Fund and the Board of Trustees harmless from any liability for payment of benefits made based upon any of information that is inaccurate or false and to repay any benefits that I incorrectly received.

Provider Signature	Date (mm/dd/yyyy)

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ACCEPTABLE RECEIPT CRITERIA

1. Date of service must be listed and in the current plan year
2. Patient responsibility* (copay, coinsurance, deductible)/goods purchased (Rx, medical equipment, etc.) must be listed on the documentation/receipt**, and dated in the current plan year
3. If an Explanation of Benefits (EOB) is provided, it must also include the name of the provider as the person receiving goods/services

REIMBURSABLE EXPENSE TYPE

Premium Expenses:

The amount that must be paid for your health plan, typically paid monthly.

Out-of-Pocket Medical Expenses:

Out-of-Pocket Medical Expenses: Your share of medical costs after your Qualified Health Plan pays its portion of expenses. Out-of-pocket costs include coinsurance, copayments and deductibles. This amount will never include your premium amount that exceeds the covered charge for out-of-network providers (also called “balance-billed charges”) or health care expenses that aren’t covered on your health plan.

Permissible Expenses (Medi-Cal Only):

Permissible Medi-Cal expenses are health care expenses that are not part of the Medi-Cal health plan. Providers who are on Medi-Cal are eligible to receive a benefit of $100 per month to reimburse permissible health care expenses. A comprehensive list is available on the website at ***www.ccpuhealth.org***

*Please note: Medical diagnosis is never needed. The Fund requires proof that payments are made for eligible expenses covered by the insurance plan and in some cases, we ill require the Provider submit proof.

**Typical proof includes information that describes the patient’s monetary responsibility (insurance covers ‘x’ amount and provider/patient must cover ‘y’ amount). Please ensure your documents clearly detail what the funds paid are for (ex. Copay: $25.00 [acceptable] vs Visa Debit: $25.00 [unacceptable])