PCCD Medical Expense Reimbursement Form for Eligible Kaiser Expenses

Complete and return this form to the Benefits Office: Peralta Community College District, 333 East 8th St, Oakland, CA 94606

First Name _____ **Last Name** _____ **SSN** _____

Home Address _____ **Year of Rtmt/ or Active** _____

City _____ **State** _____ **Zip** _____ **Phone** _____

Email of individual claiming reimbursement _____

Name of active or retired employee _____

Is there an address change? ☐ Yes ☐No

Is this your first reimbursement? ☐ Yes ☐No

Status: ☐Retired ☐Active

Peralta Affiliation: ☐Employee ☐Retiree ☐Spouse/Dependent of employee or retiree

Union Affiliation: ☐Local 39 ☐1021 ☐PFT ☐Management ☐Trustee

Guidelines/Eligibility Criteria

Use this Form if you meet the following criteria:

RETIRED EMPLOYEES

Pre July 1, 2004 retirees

- If you are a pre-July 1, 2004 retiree and have paid more than $1 for prescriptions and office co-pays, then the District will reimburse your eligible expenses, minus $1 for each prescription and/or office visit.

MAIL ORDER ONLY:

Post July 1, 2004 retirees

- If you are a Confidential, Management or Trustee member, or an active member of Collective Bargaining Agreements 1021, Local 39 or PFT, then the District will reimburse your eligible expenses minus $5 for each mail order expense incurred by you and your eligible dependents.

Post July 1, 2012 retirees

- If you are a retired member of Collective Bargaining Agreement 39, then the District will reimburse your expenses minus $30 for each brand name formulary mail order expense incurred by you and your eligible dependents.

ACTIVE EMPLOYEES

*Effective July 1, 2004, if you are a Confidential, Management or Trustee member, or an active member of Collective bargaining Agreements 1021, or PFT then the District will reimburse your expense less $5 for each mail order expense incurred by you and your eligible dependents.

*Effective July 1, 2012, if you are an active or retired member of Collective Bargaining Agreement 39, then the District will reimburse your expenses less $30 for each brand name formulary mail order expense incurred by you and your eligible dependents.

Requirements

- Requests must be accompanied by an original receipt. Claims are considered “incurred” on the date that the service was provided.
- Attach original receipts only (Kaiser drug summary sheets will not be accepted).
- All forms must be signed and dated.
- Use one form for each dependent.

Frequency

All requests received from January 1 – June 30, will be processed in July.
All requests received from July 1 – December 31, will be processed in January.

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Name _____

	Service Type (Office Visit, Mail Order Prescription)	Date of Service	Receipt Attached?	Your Expense	
1					
2					
3					
4					
5					
6					
7					
8					
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10					
11					
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25					
26					
27					
28					
29					
30					
			Total Cost/This Page	**$**	

_____ _____

Signature Line- “I am claiming reimbursement for the above-referenced prescription expenses.”

Date