Peralta Community College District
333 East Eighth Street • Oakland, California 94606 • (510) 466-7200

RETIREE HEALTH REQUEST FORM FOR REIMBURSEMENT

Use a separate claim for each healthcare professional and each individual covered. Attach itemized bill(s) for each claim.

Retiree Information

Retiree's Full Name _____ **Date of Birth** _____ **Contact Email** _____

Retiree's Mailing Address

_____

_____

Primary Telephone _____ **Date(s) of Service** _____ **Total Reimbursement Amount Requested** _____

Current Health Insurance Plan (Select one):

Anthem Kaiser Medicare Other: _____

Patient Information (Complete only if patient is not the retiree)

Patient's Full Name _____ **Relationship to Retiree** _____ **Patient's Date of Birth** _____

Patient's Primary Telephone _____ **Patient's Contact Email** _____

Patient's Mailing Address (if different from retiree)

_____

_____

Other Coverage Information

Is the patient covered under another health insurance plan? Yes No

Has the retiree or dependent filed a claim under that plan? Yes No

If yes, provide plan name and coverage details

_____

_____

Is this claim related to an accident or injury? If yes, please describe.

_____

_____

Explanation

What service or expense is being claimed?

Why is this expense not fully covered by your current health insurance plan?

(Attach a separate sheet if additional space is needed.)

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**

Return completed form with itemized bill(s) to: Peralta Community College District, Office of Human Resources – Benefits
333 East 8th Street, Oakland, CA 94606 | (510) 466-7229 | benefits@peralta.edu