P.O. Box 4100 · Concord, CA 94524-4100
Telephone: (800) 552-2400 · Facsimile: (925) 746-7549
www.ufcwtrust.com

KAISER
REIMBURSEMENT CLAIM FORM

Kaiser reimbursements will be reviewed upon receipt of all required information and in accordance with all current plan rules. All requests for reimbursement and required documentation should be submitted within 90 days from the date of service, or as soon as possible thereafter; but all reimbursement requests and required documentation must be submitted within one year from the date of service or they will be denied as untimely.

Participant ID #: ______________________

Spouse ID #: ______________________

Participant Name: ____

Spouse Name: ____

Address: ____

City: __________________________ **State:** _____________ **Zip:** _________________

Patient Name:	Date of Service:	Reimbursement Amount:
_________________________/	_______________________/	_______________________
_________________________/	_______________________/	_______________________
_________________________/	_______________________/	_______________________
_________________________/	_______________________/	_______________________

Signature of Participant: ____ **Date:** __________

Signature of Spouse: ____ **Date:** __________

Kaiser ID #: ______________________________

Attach receipts from Kaiser

Mail form to address listed above