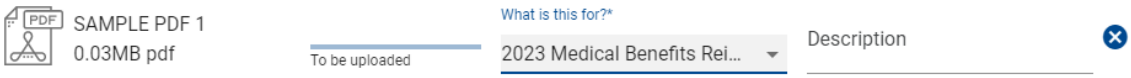
Instructions for Completing the "Medicare Advantage Reimbursement Claim Form" (For Medicare Advantage Dual Retirees and Retirees utilizing a Residual HRA)

Follow these steps to ensure your submission is complete and your claim can be processed quickly:

- ☐ Complete the "Medicare Advantage Reimbursement Claim Form" completely
  - *Your Participant Member ID Number can be found on the front of your ID Card*
- ☐ Include the following when submitting:
  - **PRESCRIPTION CLAIMS** – Submit a copy of the pharmacy Description of Service. The Description of Service is a sheet of paper that is given with the medication upon pickup, and lists the patient, date filled, and copay (among other information).

    NOTE: This is not the register receipt.
  - **MEDICAL CLAIMS** – Submit a copy of the Medicare Advantage Plan Explanation of Benefits (EOB). The Explanation of Benefits is mailed to you by your Medicare Advantage Plan after the service is complete.

    NOTE: This is not the payment receipt, or estimate of patient responsibility.
- ☐ Submit all of the above to the Trust Fund Office by mail, fax, or by scanning and uploading to your Participant Account on ufcwtrust.com.
  - Health & Welfare Services Department, P.O. Box 4100, Concord, CA 94524-4100
  - Fax: (925) 746-7549
  - To Upload, log in to your Participant Account and use the "Upload" button found on your "Correspondence" tab. Select "2023 Medical Benefits Reimbursement Form" for the question "What is this for?"



You may list multiple claims on a single claim form. Include the required documentation for PRESCRIPTION CLAIMS or MEDICAL CLAIMS listed in the Instructions above for each line item.

You may submit claims immediately upon receipt of the balance due, or at regular intervals of your choice, e.g., monthly or quarterly.

The Trust Fund Office will process your claim manually. Benefits will be issued directly to you, the Member.

To print additional copies of this form, visit the Forms Directory on ufcwtrust.com.

UFCW TRUST
Working For Your Benefit
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MEDICARE ADVANTAGE REIMBURSEMENT CLAIM FORM

Medicare Advantage 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 Member ID #: _____

Spouse Member ID #: _____

Participant Name: _____

Spouse Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Patient Name:	Date of Service:	Reimbursement Amount:
_____/	_____/	_____
_____/	_____/	_____
_____/	_____/	_____
_____/	_____/	_____

Signature of Participant: _____ **Date:** _____

Signature of Spouse: _____ **Date:** _____

Follow the Instructions on Page 1 for submitting the completed form and required documentation.