



Working For Your Benefit

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**SHINGLES VACCINATIONS, HEARING AIDS,
HRA CBD OIL, & COVID AT HOME TEST
CLAIM STATEMENT – MEDICAL BENEFITS**

PART I: TO BE COMPLETED BY THE EMPLOYEE ONLY

1. MEMBER'S NAME: _____
(LAST) (FIRST) (MIDDLE) SSN OR ID#

2. NAME OF PATIENT: _____
(LAST) (FIRST) (MIDDLE) DATE OF BIRTH

SHINGLES VACCINATION

HEARING AIDS

CBD OIL

COVID AT HOME TEST

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct and complete. I hereby authorize any physician, any hospital or insurance company to furnish and disclose all known facts concerning this disability. A copy or photocopy of this authorization shall be as valid as the original.

MEMBER'S SIGNATURE: _____ DATE: _____

PART II: FOR REIMBURSEMENT, PLEASE INCLUDE THE FOLLOWING:

1. If submitting a claim for reimbursement of a Shingles Vaccination, please ensure that you have attached both a copy of the prescription label and a copy of the receipt showing the payment amount.
2. If submitting a claim for reimbursement for the purchase of a hearing aid, please include both a copy of the invoice and a copy of the receipt showing the payment amount.
3. If submitting a claim for HRA reimbursement for the purchase of a CBD Oil please include a copy of the receipt showing the payment amount.
4. **FOR MEDICARE RETIREES ONLY**, If submitting a claim for reimbursement for the purchase of a Covid at Home Test, please submit a copy of the receipt showing the payment amount and number of units Purchased. **For Blue Shield of California Members please send your claims to Blue Shield for processing.**