**Southeastern California Conference**
**Human Resources**
11330 Pierce Street
PO Box 79990
Riverside, CA 92513-1990
(951) 509-2351
(951) 509-2395, fax

# HEALTH CARE REIMBURSEMENT REQUEST FORM

1. A separate claim form must be completed for each member.
2. Part A must be completed and signed.
3. Only original itemized statements and receipts accepted.
4. Incomplete forms will be returned.

**PART A - to be completed by the employee**
(Be sure to complete each item to avoid a delay in the payment of your claim)

| | |
|---|---|
| EMPLOYEE NAME: *(Last, First, M.I.)* | SS Number: |
| ADDRESS: *(Please include zip code)* | Is this a new address? ❑Yes ❑No |
| IS THE CLAIM FOR A DEPENDENT? ❑Yes ❑No | If Yes, give name: _____ ____Spouse ____Child ____Age |

I certify that the attached itemized bills and paid receipts are for out-of-pocket HCAP expenses (vision, hearing, and "carve-outs") for me personally or for my eligible dependents, and authorize the providers of medical services to release my information relative to the treatment or billing on these items.

SIGNATURE:_____

**PART B - must have original documents for all claims in date order**

| TYPE | DATE OF SERVICE | PAID TO: | AMOUNT | OFFICE USE ONLY |
|---|---|---|---|---|
| Vision | | | | |
| Lasik | | | | |
| Hearing | | | | |
| "Carve-outs" | | | | |