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 # *(last 4 numbers only)*:
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"				