



Reimbursement Request Form

INSTRUCTIONS

To process your reimbursement request, this form must be fully completed, signed, and returned with all required documents. You must attach a copy of your receipt that shows the dollar amount of your request, when the service occurred, and when it was paid. Please allow up to 30 days for review and processing after you submit your request for reimbursement.

Please submit to:

Mail: CCPU Health Care Fund
P.O. Box 57027
Irvine, CA 92619

Email: reimbursement@ccpuhealth.org

PROVIDER INFORMATION

Name	CCPU Health Care Fund ID	Phone Number
Address		
City	State	Postal Code
Is this a new address? <input type="checkbox"/> Yes <input type="checkbox"/> No		

EXPENSE INFORMATION (Please see the back of this form for a description of expense types.)

Type of Expense	Provider's Name	Premium Month / Date of Service	Health Plan Carrier/ Service Provider	Amount
<input type="checkbox"/> Premium Expenses <input type="checkbox"/> Out Of Pocket <input type="checkbox"/> Medical Expenses <input type="checkbox"/> Permissible Expenses (Medi-Cal Only)				
<input type="checkbox"/> Premium Expenses <input type="checkbox"/> Out Of Pocket <input type="checkbox"/> Medical Expenses <input type="checkbox"/> Permissible Expenses (Medi-Cal Only)				
<input type="checkbox"/> Premium Expenses <input type="checkbox"/> Out Of Pocket <input type="checkbox"/> Medical Expenses <input type="checkbox"/> Permissible Expenses (Medi-Cal Only)				
<input type="checkbox"/> Premium Expenses <input type="checkbox"/> Out Of Pocket <input type="checkbox"/> Medical Expenses <input type="checkbox"/> Permissible Expenses (Medi-Cal Only)				
Total Expenses:				

SIGN AND ACKNOWLEDGE

I attest that the information contained in this Request for Reimbursement is true and accurate. I am an eligible participant in the CCPU Health Care Fund program, enrolled in a qualified health plan, and seeking reimbursement for a medical health care service covered under my qualified health plan. I understand that if I provide incomplete, false or misleading information, my Request for Reimbursement may be delayed or denied. I agree to indemnify and hold the CCPU Health Care Fund and the Board of Trustees harmless from any liability for payment of benefits made based upon any of information that is inaccurate or false and to repay any benefits that I incorrectly received.

Provider Signature	Date (mm/dd/yyyy)
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REIMBURSABLE EXPENSE TYPE

Premium Expenses:

The amount that must be paid for your health plan, typically paid monthly.

Out-of-Pocket Medical Expenses:

Out-of-Pocket Medical Expenses: Your share of medical costs after your Qualified Health Plan pays its portion of expenses. Out-of-pocket costs include coinsurance, copayments and deductibles. This amount will never include your premium amount that exceeds the covered charge for out-of-network providers (also called "balance-billed charges") or health care expenses that aren't covered on your health plan.

Permissible Expenses (Medi-Cal Only):

Permissible Medi-Cal expenses are health care expenses that are not part of the Medi-Cal health plan. Providers who are on Medi-Cal are eligible to receive a benefit of \$100 per month to reimburse permissible health care expenses. A comprehensive list is available on the website at www.ccpuhealth.org