

Submit this form with proof of service for each amount to:

VCPFA Medical Benefit Trust
3251 Corte Malpaso Ste 501C
Camarillo CA 93012

Fax: (805) 484-3512 email: medtrust@vcpfa.org

Pay Me Back Claim Form

Beneficiary Information

Last Name First Name

Address

City State Zip Code Phone

Please update my contact information email

CLAIMS FOR OUT-OF-POCKET EXPENSES

INCOMPLETE FIELDS MAY RESULT IN YOUR CLAIM BEING DENIED

Quarter Year

1 Expense Type (Check All)

- Medical Premiums Dental Premiums Long Term Care
- Medicare Medicare Supplement Medicare Part D
- Other:

Expenses paid for coverage of:

- Self
- Spouse
- Qualifying Child

Total Amount Paid: \$

Month of coverage

Subscriber's Name: (If other than self)

2 Expense Type (Check All)

- Medical Premiums Dental Premiums Long Term Care
- Medicare Medicare Supplement Medicare Part D
- Other:

Expenses paid for coverage of:

- Self
- Spouse
- Qualifying Child

Total Amount Paid: \$

Month of coverage

Subscriber's Name: (If other than self)

3 Expense Type (Check All)

- Medical Premiums Dental Premiums Long Term Care
- Medicare Medicare Supplement Medicare Part D
- Other:

Expenses paid for coverage of:

- Self
- Spouse
- Qualifying Child

Total Amount Paid: \$

Month of coverage

Subscriber's Name: (If other than self)

I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible deductible expenses incurred by myself or an eligible dependent while I was a participant in the plan.

Signature of Beneficiary _____ Date

More expenses? Complete another form
Additional forms are available for download at
WWW.VCPFA.ORG
(under member resources)
or contact our office (805) 484-8844
medtrust@vcpfa.org

Submit by Email

Print Form