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.

Date ___________________________

Signature of Beneficiary

More expenses? Complete another form

Additional forms are available for download at WWW.VCPFA.ORG

or contact our office (805) 484-8844

medtrust@vcpfa.org

Submit by Email  Print Form