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

Ventura County Professional Firefighters
Medical Benefit Trust

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:

Subscriber's Name: (If other than self)

Expenses paid for coverage of:
☐ Self
☐ Spouse
☐ Qualifying Child

Total Amount Paid: $

Month of coverage

2 Expense Type (Check All)

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

Subscriber's Name: (If other than self)

Expenses paid for coverage of:
☐ Self
☐ Spouse
☐ Qualifying Child

Total Amount Paid: $

Month of coverage

3 Expense Type (Check All)

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

Subscriber's Name: (If other than self)

Expenses paid for coverage of:
☐ Self
☐ Spouse
☐ Qualifying Child

Total Amount Paid: $

Month of coverage

☐ 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