

**Reminder
one form
per patient**

**Solano-Napa Counties Electrical Workers Health & Welfare Plan
VEBA Supplemental Accumulated Share Account (SAS)
and Kaiser Deductible & Coinsurance Reimbursement Form
PO Box 1306
San Ramon, CA 94583**

Check Here for VEBA Reimbursement

Instructions for the VEBA SAS: To receive benefits from the Reimbursement Medical Account, you must complete **ONE FORM** per patient, along with the following information. Please be sure that all documents reflect the patient's name, description of service, date of service and the amount:

Reimbursement for:

- Medical Co-payments
- Dental Co-payments
- Vision payment
- Prescription Co-payment

Information Required:

- Once your Kaiser deductible has been met, a copy of your Kaiser Co-payment receipt.
Balance due statements are not acceptable.
- Copy of your dental Explanation of Benefits Form (EOB).
Orthodontic services will be paid for after services are rendered.
- Copy of your itemized vision claim.
- Copy of the drug label stub or ask your Kaiser pharmacy for a Reimbursement Receipt.
Cash register receipts are not acceptable.

OR

Check Here for Deductible & Coinsurance Reimbursement

Instructions for Kaiser Deductible & Coinsurance Reimbursement: To receive benefits from the Plan, you must first accumulate \$250 in Kaiser charges which were applied to your deductible or are for coinsurance you were required to pay and then complete this form and submit it along with a copy your Kaiser bill or Summary of Account (SOA) and proof of payment. Please be sure that all documents reflect the patient's name, description of service, dates of service and the amounts.

NOTE: REIMBURSEMENT REQUESTS FOR COPAYMENTS, OPTICAL BENEFITS AND OTHER CHARGES THAT ARE REIMBURSABLE UNDER THE SUPPLEMENTAL ACCUMULATED SHARE ACCOUNT (SAS) VEBA\ HRA ARE NOT REIMBURSABLE UNDER THE KAISER DEDUCTIBLE AND COINSURANCE REIMBURSEMENT PROVISION.

Participant's Name: _____ Participant's SS#: _____

Address: _____

Phone Number: (Home) _____ (Work) _____

Patient Name: _____ Relationship: _____
one patient per form to participant

Type of Service <small>(Medical, Dental, Vision, Prescription, Deductible or Co-insurance)</small>	Providers Name <small>(Dr. Name/Office Name)</small>	Date of Service <small>(The Date Patient Sought Services)</small>	Amount of Claim <small>(Reimbursement you are requesting)</small>
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____

By signing this form, I understand that benefits shall be paid in accordance with the Reimbursement Medical Account Plan eligibility requirements and limitations established by the Board of Trustees.

Member's Signature: _____ Date: _____

