

VEBA

**Solano-Napa Counties Electrical Workers
Reimbursement Medical Account Plan
PO Box 1306
San Ramon, CA 94583**

Instructions: To receive benefits from the Reimbursement Medical Account, you must complete **ONE FORM** per patient, along with the following information:

Reimbursement for:

Medical Co-payments

Dental Co-payments

Vision payment

Prescription Co-payment

Information Required:

Copy of your Kaiser Explanation of Benefits (EOB).

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 a printout from your pharmacy.

Cash register receipts are not acceptable.

PLEASE NOTE: You MUST allow up to 30 business days for reimbursement. All reimbursements for claims will be made payable to the participant.

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

Address: _____

Phone Number: (Home) _____ (Work) _____

Patient Name: _____ Relationship: _____

Type of Service <small>(Medical, Dental, Vision or Prescription)</small>	Providers Name	Date of Service	Amount of Claim
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____

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: _____