

SACRAMENTO AREA ELECTRICAL WORKERS

Health Net HMO Deductible Reimbursement Form

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

Address: _____

Phone Number: (Home) _____ (Work) _____

Patient Name: _____ Relationship: _____

Type of Service	Provider's Name	Date of Service	Claim Amount*
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____

* Claims on form must only be submitted for Hospital Inpatient claims, Outpatient Surgery claims or MRI, CT Scan and MUGA Procedure claim. Claims submitted for Hospital Inpatient claims must total at least \$500.00. (This constitutes proof of the individual's responsibility of \$250.00 and submission for reimbursement of \$250.00)

By signing this form, I understand that benefits shall be paid in accordance with the guidelines and limitations established by the Board of Trustees. (See the enclosed form for a brief description of covered benefits).

Participant's Signature: _____ Date: _____

Instructions: To receive reimbursement from the Sacramento Area Electrical Workers Health and Welfare Plan, you must complete **ONE FORM PER PATIENT** and submit the following information:

1. Copy of your Explanation of Benefits (EOB) from Health Net. (Receipts or Balance Due Statements from your doctor's office are not acceptable.)
2. Receipts or cancelled checks proving the amounts have been paid.

PLEASE NOTE: The Plan will reimburse up to \$1,750 per covered member (up to three per family) of the Hospital Inpatient Copayment after you pay the first \$250. Maximum reimbursement will be \$1,750 for four days of hospitalization, \$1,250 for three days, \$750 for two days, and \$250 for one day. The Plan will also reimburse \$250 per procedure for outpatient surgery, as well as \$50 per procedure for MRI, CT Scan, and MUGA. You MUST allow up to 30 business days for reimbursement. All reimbursements for claims will be made payable to the participant.

MAIL TO: Sacramento Area Electrical Workers Health and Welfare Plan
c/o United Administrative Services
P.O. Box 5057
San Jose, CA 95150

For Administrative use only:			
Control ID: _____	Processing date: _____	Disp: _____	Init: _____