



## PCCD Medical Expense Reimbursement Form For Eligible Kaiser Expenses

Complete and return this form to the Benefits Office: Peralta Community College District, 333 East 8<sup>th</sup> St., Oakland, CA 94606

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ SSN \_\_\_\_\_

Home Address \_\_\_\_\_ Year of Rtmt/or NA \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Check here if this is an address change

Name of active or retired employee: \_\_\_\_\_

**Status**

Circle One:      Retired                  Active

**Peralta Affiliation**

Circle One:      Employee/Retiree    Spouse/Dependent of employee or retiree

**Union Affiliation**

Circle One:      39          1021      PFT      Not Applicable

### Eligibility Criteria

Use this form if you meet the following criteria:

- You are a pre-July 1, 2004 retiree and have paid more than \$1 for your office co-pays or prescriptions
- You are an active employee at the time of service and paid more than \$5 for mail order prescriptions
- You are submitting expenses incurred within 12 months of the date of service

### Guidelines

\*\*\* Use one form for each dependent

\*\*\* Reproduce form as necessary

\*\*\* Attach receipts

▪ **Pre July 1, 2004 retirees**

\*\* If you are a pre-July 1, 2004 retiree and have paid more than \$1 for prescriptions and office co-pays, then the District will reimburse your eligible expenses, less \$1 for each prescription and/or office visit.

▪ **Post July 2004 Retirees**

▪ **Active employees, all groups**

\*\* If you are an active member of Collective Bargaining Agreements 39, 1021 and PFT, then the District will reimburse your expense less \$5 for each mail order expense incurred by you and your eligible dependents.

### Frequency

Reimbursements are processed semi-annually. All requests received by June 30, will be processed in July.  
Reimbursement requests received on or after July 1, will be processed the following January.

					To be completed by Benefits Office	
#	Indicate Service Type (Office Visit, Mail Order Prescription)	Date of Service	Receipt Attached?	Your Expense		Amount to Reimburse
1)						
2)						
3)						
4)						
5)						
6)						
7)						
8)						
9)						
10)						
				<b>Page 1 Total</b>	\$	
				<b>Page 2 Total</b>	\$	

**I am requesting reimbursement for services incurred within the last 12 months**



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Name \_\_\_\_\_

					To be completed by Benefits Office	
	Indicate Service Type (Office Visit, Mail Order Prescription)	Date of Service	Receipt Attached?	Your Expense		Amount to Reimburse
10)						
11)						
12)						
13)						
14)						
15)						
16)						
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30)						
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32)						
33)						
34)						
35)						
<b>Total Cost/This Page</b>				\$		