VCCCD Retiree Application for Reimbursement of Medical Costs Above Baseline Plan

Retiree Information			Dependent Information (if claim(s) submitted)
Retiree Social Security # **Retiree Date of Birth:** **Age 75-79** ☐ **80 or over:** ☐			**Last Name,** **First Name**
Last Name, **First Name**			**Relationship to Subscriber:** **Spouse/Domestic Partner** ☐ **Child** ☐
Address			**Last Name,** **First Name**
City	**State**	**Zip Code**	**Relationship to Subscriber:** **Spouse/Domestic Partner** ☐ **Child** ☐
Grand Total for Amount Above Baseline Plan **$**			**Retiree Phone Number** **( )**
Retiree's Signature **Date**			
Designee (In the event of retiree's death prior to payment) **Name** **Address** **City** **State** **Zip Code**			

Instructions

1. Complete application form.
2. Proof of payment of costs above baseline plan **must** be included for reimbursement
3. Only one reimbursement form may be filed per health benefit year (July 1 – June 30)
4. Keep copies of all for your file, and return the application and proof of payment on or before September 30th of the immediate preceding health benefit year (July 1 – June 30) to:

Ventura County Community College District
Employee Benefits
255 W. Stanley Ave., Suite 150
Ventura, CA 93001

(Complete back of form and attach proof of payment)

Inventory of Medical/Prescription Costs Above Baseline Plan

USE A SEPARATE INVENTORY PAGE FOR EACH MEMBER OF THE FAMILY SUBMITTING A REQUEST FOR REIMBURSEMENT; USE ADDITIONAL PAGES FOR EACH MEMBER IF NECESSARY **PAGE____ OF ____**

Medical, Dental, Vision Expense Copy of Explanation of Benefits must be attached	Retail Pharmacy Prescription Copy of prescription co-pay invoice that includes the patient name must be attached (Cash register receipt only will not be accepted)	Mail Order Prescription Copy of prescription co-pay invoice that includes the patient name must be attached
Patient Name:	**Patient Name:**	**Patient Name:**
Date of Service:	Date of Service:	Date of Service:
Amount Paid Above Baseline:	Co-Pay Above Baseline:	Co-Pay Above Baseline:
Service Performed:	**Patient Name:**	**Patient Name:**
Patient Name:	Date of Service:	Date of Service:
Date of Service:	Co-Pay Above Baseline:	Co-Pay Above Baseline:
Amount Paid Above Baseline:	**Patient Name:**	**Patient Name:**
Service Performed:	Date of Service:	Date of Service:
Patient Name:	Co-Pay Above Baseline:	Co-Pay Above Baseline:
Date of Service:	**Patient Name:**	**Patient Name:**
Amount Paid Above Baseline:	Date of Service:	Date of Service:
Service Performed:	Co-Pay Above Baseline:	Co-Pay Above Baseline:
Patient Name:	**Patient Name:**	**Patient Name:**
Date of Service:	Date of Service:	Date of Service:
Amount Paid Above Baseline:	Co-Pay Above Baseline:	Co-Pay Above Baseline:
Service Performed:	**Patient Name:**	**Patient Name:**
Patient Name:	Date of Service:	Date of Service:
Date of Service:	Co-Pay Above Baseline:	Co-Pay Above Baseline:
Amount Paid Above Baseline:	**Patient Name:**	**Patient Name:**
Service Performed:	Date of Service:	Date of Service:
Patient Name:	Co-Pay Above Baseline:	Co-Pay Above Baseline:
Date of Service:	**Patient Name:**	**Patient Name:**
Amount Paid Above Baseline:	Date of Service:	Date of Service:
Service Performed:	Co-Pay Above Baseline:	Co-Pay Above Baseline:
Patient Name:	**Patient Name:**	**Patient Name:**
Date of Service:	Date of Service:	Date of Service:
Amount Paid Above Baseline:	Co-Pay Above Baseline:	Co-Pay Above Baseline:
Service Performed:	**Patient Name:**	**Patient Name:**
Patient Name:	Date of Service:	Date of Service:
Date of Service:	Co-Pay Above Baseline:	Co-Pay Above Baseline:
Amount Paid Above Baseline:	**Patient Name:**	**Patient Name:**
Service Performed:	Date of Service:	Date of Service:
Patient Name:	Co-Pay Above Baseline:	Co-Pay Above Baseline:
Date of Service:	**Patient Name:**	**Patient Name:**
Amount Paid Above Baseline:	Date of Service:	Date of Service:
Service Performed:	Co-Pay Above Baseline:	Co-Pay Above Baseline:
Total Medical $ ____________	**Total Retail Pharmacy $ __________**	**Total Mail Order Rx $ ___________**

~ Employer Use Only ~

$______________________________ ______________________ __________________________

Amount Approved for Reimbursement **Date** **Signature of Authorized Person**

Notes: