



Redwood Health Services

Fax completed form to 707-525-4223 or mail to RHS at address below.

RHS Reimbursement Form

Group Name _____ Member ID# _____

Employee Last Name _____ First _____

Address _____ City _____ State _____ Zip _____

Requested Reimbursements Note: Each item *must* be accompanied by proper documentation. See instructions below.

Item	Patient Name	Date of Service	Relationship to Employee	Service Description	Reimbursement Amount
1					
2					
3					
4					
5					
6					
7					
TOTAL					

Employee Certification

I certify that the information above is true and correct; that I have paid the provider of service; that the expenses incurred were for myself, spouse, or qualified dependents; and that I have not been reimbursed and will not seek reimbursement from any other source.

Employee Signature: _____ Date: _____

Instructions

- Each item **must** be accompanied by **either** an Explanation of Benefits (EOB) from your primary carrier **or** a detailed receipt.
- Each EOB must show the patient name, the date of service, and the amount paid by your primary carrier.
- Each receipt must show the amount paid and the specific product or service purchased (for example, a prescription drug).
- Fax form and documentation to **707-525-4223**, or mail to

Claims Processing
 Redwood Health Services
 3033 Cleveland Ave. #104
 Santa Rosa, CA 95403

5. Questions? Call RHS Customer Service at **800-548-7677**.