Redwood Health Services

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

HRA Reimbursement Form

Group Name ______________________ Member ID# ______________

Employee Last Name ______________________ First ______________

Address ______________ City ______________ State ______ Zip ______

☐ Address change *(check box if applicable)*

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

1. Each statement **must** be accompanied by a detailed receipt.
2. Each statement must show the patient name, the date of service, and the amount due.
3. Each receipt must show the amount paid and the specific product or service purchased (for example, a prescription drug).
4. Fax form and documentation to **707-525-4223**, or mail to

   Claims Processing
   Redwood Health Services
   3510 Unocal Place, Suite 108
   Santa Rosa, CA 95403

5. **Questions?** Call RHS Customer Service at **800-548-7677, option 2**.

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