Redwood Health Services

Reimbursement Form

Fax completed form to **707-525-4223** or mail to:
Redwood Health Services • 3510 Unocal Place, Suite 108 • Santa Rosa, CA 95403

Group Name ______________________ Contact Phone Number ______________________

Employee Last Name ______________________ First ______________________

Address ______________________ City ______________________ State ________ Zip ____________

Address change *(check box if applicable)* ☐

UNREIMBURSED MEDICAL EXPENSES – List each separately ☐ HRA ☐ FSA ☐ Self-Insured

	Patient Name	Date of Service	Provider of Service	Service Description	Reimbursement Amt
1					
2					
3					
4					
5					
				TOTAL	

Attach an Explanation of Benefits showing patient name, date of service, and amount paid. If medical expenses are not supported by the proper documentation (e.g. receipts, EOBs), then by signing below you certify that you have not been reimbursed and will not seek reimbursement from any other plan of health benefits. **Employee Certification:** ______________________ **Date** : ______________

DEPENDENT CARE EXPENSES – List each separately

	Dependent Name	Date of Service	Provider of Service/ID#	Service Description	Reimbursement Amt
1					
2					
3					
4					
5					
				TOTAL	

TRANSPORTATION EXPENSES – List each separately

	Service Description	Reimbursement Amt
1		
2		
3		
4		
5		
	TOTAL	

Attach an itemized bill and receipt of payment showing dependent name, date of service, provider of service/ID# and amount paid.

I request reimbursement as listed above and certify that these are eligible medical and/or dependent care expenses that my dependents or I have incurred. I certify that the medical expenses qualify as deductible expenses for federal income tax purposes, meet the requirements of the Plan document and will not be reimbursed by any other source or used as a deduction on my personal income tax return(s). Further, I certify that the dependent care expenses qualify as valid expenses under the Plan document, that I will not seek reimbursement of the expenses from any other dependent care plan and that I will not use the expenses for a deduction or credit on my personal income tax return(s). Further, by requesting reimbursement of dependent care expenses, I understand that I must file IRS Form 2441 with my federal income tax return. I hereby authorize the Plan and its service provider (RHS), and their respective agents, employees, sub-contractors, and assigns to use the information provided above to administer the Plan (including the evaluation of eligibility for reimbursement under the Plan) and to detect or prevent fraud or misrepresentation and to further disclose any and all such information as is reasonably required for such purpose. I further authorize any provider, insurer, or other entity to release any health or treatment information for the purpose of determining eligibility for Plan benefits or to detect or prevent fraud. I hereby expressly waive and release any claims related to the use, disclosure, or release of information so long as the information is used in furtherance of administering the Plan (including the processing or evaluating my claim for benefits under the Plan) or detecting or preventing fraud. This authorization does not and is not intended to in any way limit any right the Plan, RHS, or their respective agents, employees, sub-contractors, and assigns may have under applicable state or federal law or regulation regarding the use of such information.

Employee Signature: ______________________ **Date:** ______________