



Group Name _____ Member ID# _____

Employee Last Name _____ First _____

Address _____ City _____ State _____ Zip _____

Address change (check box if applicable) Phone # _____

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. Scan and email form and documentation to: **cwarren@rhs.org** or fax form and documentation to **707-525-4223**, or mail to: **Claims Processing**
Redwood Health Services
3510 Unocal Place, Ste. 108
Santa Rosa, CA 95403

Questions? Call RHS Customer Service at **800-548-7677, ext 108.**

