Redwood Health Services — Claims Reimbursement Form

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	$ 0.00

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 me, my 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. Complete the fillable PDF form, sign electronically, and email to **dsunday@rhs.org** (preferred) *or*
   Scan & email the form and documentation to: **dsunday@rhs.org** *or* Fax the form and documentation to **707-525-4223**, *or* Mail to: **Claims Processing**
   Redwood Health Services
   3510 Unocal Place, Ste.108
   Santa Rosa, CA 95403

Note: For reimbursement by Direct Deposit to an account of your choice, download and complete the **Direct Deposit Reimbursement Form** and return to: rhscustomerservice@rhs.org.

Questions? Email rhscustomerservice@rhs.org. • 800-548-7677, opt 2 • www.rhs.org