REIMBURSEMENT REVIEW AND APPEAL FORM

HOMECARE WORKER
Supplemental & Benefits Trusts

FIRST CALL 1-844-507-7554

Worker Name **Last**: _____ **First:** _____

Address: _____ Phone #: _____

Email Address: _____ SSN: _____

IF THE REQUIRED DOCUMENTATIONS ARE NOT ATTACHED, YOUR REVIEW CANNOT BE PROCESSED. Members reimbursement eligibility will be decided within 30 days of receipt of all documents necessary.

Please check the box that best describes you reason for the review:

Eligibility Re-Determination for Dental, Vision and Employee Assistance Program. ☐
(Requires documentation for hours worked during the time period affected)

Reimbursement Amount was Paid Incorrectly. ☐
(Send copies of the Reimbursement Form and Documentation Required on that Form)

Reimbursement Amount was not paid. ☐
(Fill out or resend the Reimbursement Claim Form and required Documentation)

Reimbursement was mailed to the wrong address. ☐
(Please call your employer to update your address so that the check can be resent)

Other Issues, please specify. _____ ☐

Please Mail or Fax this form and supporting documents to:

Mail: Oregon Homecare Workers Trust, PO Box 6, Mukilteo, WA 98275
Fax: Oregon Homecare Workers Trust, 1-866-459-4623
Email: OHCWT@bsitpa.com Subject: OHCWT Reimbursement
Phone: 844.507.7554

I certify that these statements are true and that the claimed expenses have been incurred as indicated.

Worker Signature: _____ Date: _____