HOMECARE WORKER

Supplemental & Benefits Trusts

Providing Benefits to Oregon Homecare and Personal Support Workers

MEDICAL REIMBURSEMENT CLAIM FORM

Last Name	**First Name**
Mailing Address	**City, State, Zip**
Social Security Number	**Date of Birth**
Email	**Preferred Language**
Contact Phone	**Best Time to Call**

ITEM **REQUESTED REIMBURSEMENT**

Medicare Part B Premium $_____

Proof of Part B premium and effective date of coverage must be provided when you first become eligible.

Medicare Advantage Plan, Supplement Plan or Part D or Rx Plan (up to $44) $_____

Proof of premium for a Medicare Advantage Plan, Supplement Plan OR Part D Plan, and effective date of coverage, must be provided when you first become eligible and annually thereafter.

Medical Premium Reimbursement $_____

Monthly Proof of Medical Premium and proof of payment must be provided for each month reimbursement is requested.

Medical Out-of-Pocket Expenses $_____

Up to $4000 per calendar year in 2017 and up to $5,000 in 2018. Explanation of Benefits from your insurance company or pharmacy receipt with prescription issued must be provided for every reimbursement request.

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

Phone: 1-844-507-7554 Option 3, then select Option 2

I certify that the information provided on this form is true and that I have incurred the expenses described on this form solely relating to my own medical coverage and expenses. I also certify that I have not already received reimbursement from the Supplemental Trust or any other source for any of the above-listed amounts.

Signature: _____ Date: _____