HOMECARE WORKER

Supplemental & Benefit Trusts

Providing Benefits to Oregon Homecare and Personal Support Workers

Medicare Reimbursement Claim Form

Legal name (Last, First, MI) _____

Home Address _____

City _____ **State** _____ **Zip** _____

Date of Birth _____

Provider Number _____ **Gender** _____ **Preferred Language** _____

Home Email Address _____

☐ *I understand by checking this box, I am indicating I would like to receive information and updates from the Trusts via email*

☐ *I would like to opt out of receiving information and updates from the Trusts via email*

Home Phone _____ **Mobile Phone** _____

By providing my phone number, the Trusts may use automated calling technologies and/or text message me on my cellular phone on a periodic basis. The Trusts will never charge for text message alerts. Carrier message and data rates may apply to such alerts. Reply STOP to stop receiving messages, reply HELP for more information. If you would like to opt out of text messages, please check this box ☐

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 Out-of-Pocket Expenses **$** _____

Up to $5000 per calendar year in 2018 and up to $6,000 in 2019. Explanation of Benefits from your insurance company or pharmacy receipt with prescription issued must be provided for every reimbursement request.

Please DocuSign, Fax or Mail this form and supporting documents to:

DocuSign: www.orhomecaretrust.org/reimbursement/
Fax: Oregon Homecare Worker Trust, 1-866-459-4623
Mail: Oregon Homecare Worker Trust, PO Box 6, Mukilteo, WA 98275
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: _____