HOMECARE WORKER

Supplemental Trust

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 $6000 per calendar year in 2019 and up to $6,190 in 2020. 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/medicare
**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: _____



*The benefits of the Homecare Workers Supplemental and Benefit Trusts were negotiated by SEIU Local 503 homecare and personal support workers through their bargaining team.*

P.O. BOX 6, MUKILTEO, WASHINGTON 98275 *website:* orhomecaretrust.org
*Trust Administration:* 844-507-7554 *fax:* 866-459-4623 *email:* OHCWT@vimly.com

LOCAL 503 SEIU Stronger Together