P.O. Box 4100 · Concord, CA 94524-4100
Telephone: (800) 552-2400 · Facsimile: (925) 746-7549
www.ufcwtrust.com

KAISER
REIMBURSEMENT CLAIM FORM

Kaiser reimbursements will be reviewed upon receipt of all required information and utilizing all current plan rules.

Participant ID #: ______________________

Spouse ID #: ______________________

Participant Name: ____

Spouse Name: ____

Address: ____

City: ___________________________ **State:** _____________ **Zip:** _________________

Patient Name:	**Date of Service:**	**Reimbursement Amount:**
_________________________/	_________________________/	_________________________
_________________________/	_________________________/	_________________________
_________________________/	_________________________/	_________________________
_________________________/	_________________________/	_________________________

Signature of Participant: ____ **Date:** __________

Signature of Spouse: ____ **Date:** __________

Kaiser ID #: ________________________________

Attach receipts from Kaiser

v.001 20190213

Mail form to address listed above