San Diego Fireman's Relief Association (SDFRA)
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San Diego CA 92108
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Reimbursement Claim Benefit Form

SDFRA.V5 2/6/2020

Member Full Name (Last Name, First, MI)	Member SDFRA Account #
Member Address (Street, City, State, ZIP Code) Is this a new address? (Please circle one) Yes No	
Email address:	Phone# (Please circle one) Cell Home

Medical and Flex Claim(s)

Relationship (enter M or D) M-Member/Self D-Child or Spouse	**Name of Member or Dependent** (that received the service being submitted and that is listed on your supporting documentation)	**Provider Name** (Name of the medical provider, pharmacy, dentist, Gym etc.)	**Benefit Type (1)** (*Select the appropriate **M or D** code below)	**Date of Service**	**# of Services** (2)**	**Amount Submitted**
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$

(1) *Benefit Type - Select and enter **one** of these eligible benefit types listed in red for each claim line above. Each claim line must be submitted with a supporting document attached.

Total Submitted	$

M – Member Benefit Type

MCOP - Medical Visit
MRXR – Pharmacy
MDED - Member Deductible
FDEN – Dental
FVIS – Vision
FGYM – GYM
FAHI - Home/Auto

D – Dependent/Spouse Benefit Type

DCOP - Medical Visit
DRXR – Pharmacy
FDEN – Dental
FVIS – Vision
FAHI - Home/Auto

(2) ** # of services – Enter the number of medical visits services, hospital days or number of months refilled on RX supported by your receipt or document. Example: RX A-90-day supply would be 3 services for three months. If the patient was in the hospital list the number of days as an Inpatient.

(3) For additional questions please see the instructions ***How to Complete "Reimbursement Benefit Claim Form*** on the back or call our office.

Authorization and Certification

By my signature I certify that my statements on this Claim Form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for my eligible dependents. I understand that it is my responsibility to submit only eligible expenses defined by SDFRA's parameters. I certify that these expenses have not been, nor will be, reimbursed by any other benefit plan and will not be claimed as an income tax deduction. By submitting this Claim Form, I hereby acknowledge that SDFRA will obtain and use such information for purpose of administering my SDFRA benefits.

Member Signature _____ Date _____

How to Complete this "Reimbursement Claim Benefit Form"

Section 1 Member Information Please enter the member information. (*Your SDFRA Account number will be made available in the future and may be left blank at this time.)*

Section 2 Medical and Flex Claims(s)

This section is completed by referencing your supporting documentation which must be submitted for each claim line. **Supporting Documentation (SD or receipt)** such as a bill, invoice, receipt, EOB or other document that supports the expense as submitted and the responsible parties.

- *Relationship* – If the receipt is for you, the member a "M" is entered in this box. For any of your dependents/spouse you would enter a "D".
- *Patient Name* – Refer to your **Supporting Documentation or (SD)** you are submitting for payment.
    - **Medical Services & Flex Medical Services (dental & vision)** - Enter the name of the member or dependent that received the services and whose name is listed on the SD.
    - **Flex Home or Auto** - Enter the name of the member or dependent on the SD.
    - **Flex GYM (a member only benefit)** – Enter the member's name that matches the responsible party on the bill, statement or receipt.
    - Please enter all claims for the same person's in succession before moving to a different dependent or member.
- *Provider Name* – This is the name of the provider on the SD you are submitting with the claim form. Examples:
    - CVS – might be your pharmacy provider
    - Name of the dental or vision provider
    - Name of the GYM paid for members fitness club
    - Name of the insurance company if submitting deductible or premium receipt for the home or auto annual $50 benefit.
- *Benefit Type –* If the receipt on this claim line if for a member select the code in **red** in the "Member Benefit Type" box. If the receipt is for a Dependent, a code in the "Dependent/Spouse Benefit Type" box must be used.
- *Date of Service* – This is the day the service was performed or provided that is documented on the SD you are submitting.
- *# of Services* – The number of services is based on the SD.
    - Pharmacy quantity is the number of 30 days supplies provided on the receipt. If you have a 90-day supply of medication the # of services is 3. One for each 30 days. If your receipt does not list the number of days, please write it on the receipt as well as the claim form.
    - Office-visit-co-pay would be number of visits paid for on that receipt.
    - Span of Services – In some cases a receipt will have multiple services on different dates. For examples:
        - Chiropractic visits – You may have a receipt for multiple visits on different days. You would enter the total number of visits shown on the statement.
        - Admissions – If you or a dependent is admitted into a medical facility and you have a statement that shows the admission through discharge information please list the number of days in the facility. The date of discharge is not counted so if you were admitted on November 28 and discharged on December 5th you would enter 6 services.
- *Amount Submitted* – Is the amount you are due out of pocket and requesting be considered for reimbursement.

Total Submitted – Total of receipts submitted with the form.

Section 3 Authorization and Certification – Is signed and dated by our SDFRA member.

Other Information

- Submit the claim by mail or email at the address on the claim form.
- Use as many claim forms as needed to submit all of your receipts.

To be eligible for reimbursement, you must submit an accurately completed and signed claim form with copies of your supporting receipts/documents within 6 months (180 days) of the date of the expense/loss/service. All claims submitted are subject to membership and benefit eligibility. Do not send medical records identifying medical conditions, diagnosis, or specific treatments. Those records are protected under the Health Insurance Portability and Accountability Act (HIPPA).