Reimbursement Claim Form

San Diego Fire Relief Association
10509 San Diego Mission Rd. Ste. F San Diego CA 92108
Phone (619)281-0354
Fax (619) 281-8325

Member Information

Member Full Name (Last Name, First, MI)			SDFRA Member ID:
Address:	City:	State:	Zip:
Is this a new address? (Please select yes or no). ◯ Yes ◯ No	Primary Email Address:		Primary Phone: ◯ Home ◯ Cell

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**	**SDFRA Internal use only**
						$	
						$	
						$	
						$	
						$	
						$	
						$	
						$	
						$	
						$	

Benefit Type

M- Member	**D- Dependent/ Spouse Benefit Type**	**** Pharmacy # Services**
MCOP - Medical Visit **MRXR** – Pharmacy **MDED** - Member Deductible **FDEN** – Dental **FVIS** – Vision **FAHI** – Home/Auto **MFGYM** – GYM	**DCOP** - Medical Visit **DRXR** – Pharmacy **FDEN** – Dental **FVIS** – Vision **FAHI** – Home/Auto **MFGYM** – GYM	(or days' supply) 1 – 30 = 1 Service 31 – 60 = 2 Services 61 – 90 = 3 Services 1 – 180 = 6 Services

(2) **#ofservices–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:_________________________