

No. California Sheet Metal Workers Health Care Plan

Medical Reimbursement Claim Form

PO Box 1677

San Ramon, CA 94583

Phone: (925) 208-9992 or (800) 787-0162, Fax: (925) 297-6655

Information Required for Processing:

- ✓ Itemized bill reflecting proof of payment
- ✓ Provider's name, address, phone number & Tax ID
- ✓ Procedure Code (CPT) and Diagnosis Code (ICD)
- ✓ Cash register receipts alone are not acceptable

Member's Name: _____

Member's DOB: _____ Alt ID or Last 4 SSN: _____

Address: _____

Phone Number: (Home) _____ (Work) _____ (Cell) _____

Patient Name: _____ Patient's DOB: _____

Provider's Name: _____ Tax Id: _____

Provider's Address: _____

Provider's Phone #: _____

CPT: _____

ICD: _____

Date of Service	Provider	Billed Amount
-----------------	----------	---------------

_____	_____	_____
-------	-------	-------

_____	_____	_____
-------	-------	-------

_____	_____	_____
-------	-------	-------

_____	_____	_____
-------	-------	-------

_____	_____	_____
-------	-------	-------

Member's Signature: _____ Date: _____