

Hotel and Restaurant Employees Health and Welfare Trust Fund
East Bay Restaurant and Tavern Retirement Plan
1182 Market Street, Suite 320 • San Francisco • California • 94102-4919
Telephone: (844) 492-9159

REQUEST FOR REIMBURSEMENT OF DURABLE MEDICAL EQUIPMENT

Your request for reimbursement must include this completed claim form along with a copy of the physician's prescription for the equipment and itemized copy of the billing from the provider that includes the following information:

- Full Provider Name
- The Provider Tax ID #
- CPT/HCPS Codes for the required equipment
- Diagnosis for which the equipment is being prescribed

Please complete the section below and return all required information to:

Hotel and Restaurant Employees Health and Welfare Trust Fund
Attention: Claims Manager
P.O. Box 555 • San Ramon, CA 94583

Member Name: (Please Print) _____

Member ID#: _____ Member Date of Birth: _____

Member Address: _____

_____ Phone Number: _____

Patient Name: _____ Relationship to Member: _____

Patient Date of Birth: _____ Patient ID# _____

Patient Address (if not the same as the Member): _____

Is there any other type of Medical insurance that will be covering this equipment?
(i.e. Medicare, Individual Plan, other Group Coverage) Yes No

If Yes, please provide the name and contact information for the Other Insurance: _____

I certify that the above and/or attached information is correct to the best of my knowledge.

Member Signature

Date