KAISER – EARLY RETIREE REIMBURSEMENT CLAIM FORM FOR COPAYMENT REFUND

INSTRUCTIONS

1. **Complete, date and sign the claim form.**
2. **Attach proof of prescription co-payment(s) paid to Kaiser.**
3. **Submit Part One of the claim form and proof of payment to the address shown below.**
4. **Remove and retain Part Two for your records.**

Web: www.scibew-neca.org

PART ONE – RETIREE INFORMATION

Web: www.scibew-neca.org

Last Name	First Name	SSN				-			-				

Address	City	State	Zip Code	Phone Number

	Patient' s Last Name	Patient's First Name	Total amount billed	# of RX	Date(s) RX Dispensed	
Self					1)	2)
					3)	4)
Spouse					1)	2)
					3)	4)

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Important: Proof of payment must include the patient's name, date, RX# and co-payment amount

Retiree's Signature	Date Signed	Spouse's Signature	Date Signed

RETURN TO ALLIED ADMINISTRATORS
2831 Camino Del Rio South, Suite 311
San Diego, CA 92108-3829
Telephone: (800) 736-0401

PART TWO – RETIREE'S PORTION – FOR YOUR RECORDS ONLY

KAISER EARLY RETIREE– RX COPAYMENT REIMBURSEMENT CLAIM RECEIPT

	Patient' s Last Name	Patient's First Name	Total amount billed	# of RX	Date(s) RX Dispensed	
Self					1)	2)
					3)	4)
Spouse					1)	2)
					3)	4)

This form is also available online at www.scibew-neca.org