Connected Care High Deductible Health Plan (HDHP)
Extra Bucks Reimbursement Claim Form

FAXES NOT ACCEPTED.
Please mail this form to: **Address: KPIC Self-Funded Claims Administrator**
P.O. Box 30547
Salt Lake City, UT 84130-0547

If you would like help with this form, contact the Connected Care Customer Service at Kaiser by calling **1-844-533-2885**, Monday through Friday from 8 a.m. to 5 p.m. PST

EMPLOYEE INFORMATION

The employee or primary policy holder must complete this section.

First Name, MI, Last Name		Member ID Number:			
Address (No P.O. Boxes)		City	State	County	ZIP Code
Home Phone	Work / Message Phone	E-mail Address			

EXTRA BUCKS REIMBURSEMENT INSTRUCTIONS

You must complete both pages of this form. Once we receive your completed form, your reimbursement request will be processed within 30 days. We will adjust the reimbursement amount if any part of a receipt cannot be processed for any reason. Keep a copy of the form and all supporting documentation for your records.

1. Review the eligible expense listing and FAQ's. Complete all sections (as appropriate) of this reimbursement form.
2. Attach original itemized receipts, required documentation and any supporting information as needed to support the reimbursement. Tape small receipts to an 8 ½ X 11" piece of paper.
3. Mail this original form with your signature (not copies of the form) to the address listed above.

SERVICES RECEIVED (ALSO COMPLETE THE SECOND PAGE OF THIS FORM.)

Complete the information below for yourself or your legal spouse, domestic partner, or dependent child(ren) who received the service(s) for this claim. Dependent child(ren) must be younger than age 26.

Name (First Name, MI, Last Name)	**Relation**	**Member ID**	**Date of Service**	**Amount**
1.	Self ☐ Spouse ☐ Child ☐			
2.	Self ☐ Spouse ☐ Child ☐			
3.	Self ☐ Spouse ☐ Child ☐			
4.	Self ☐ Spouse ☐ Child ☐			
5.	Self ☐ Spouse ☐ Child ☐			
6.	Self ☐ Spouse ☐ Child ☐			
			TOTAL OF ALL REQUESTS	**$**

I certify that I and/or my eligible dependents have incurred the above expenses.

Signature: _____ **Date:** _____

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A PROVIDER OR PHARMACY RECEIPT MUST BE ATTACHED FOR REIMBURSEMENT TO BE PROCESSED. REFER TO THE INTEL INTRANET SITE, CIRCUIT, FOR COVERED BENEFITS. PLEASE BE SURE THAT YOU UNDERSTAND THE TYPES OF EXPENSES THAT ARE ELIGIBLE FOR REIMBURSEMENT BEFORE YOU SUBMIT THIS FORM.

1. You can use your Extra Bucks on qualified expenses **after** your plan deductible is met. To view a comprehensive list of qualified expenses, please visit Circuit

Indicate the type of reimbursement you are requesting, and complete the required information in the first section, for the allowable expenses (after your deductible is met):	
	Out-of-pocket costs (coinsurance) for medical covered benefits. Provide a description of the service received below:
	Out-of-pocket expenses (coinsurance) for covered Pharmacy expenses.

2. You can also use your Extra Bucks on the qualified expenses **before** your plan deductible is met. To view a comprehensive list of qualified expenses, please visit Circuit

Indicate the type of reimbursement you are requesting, and complete the required information in the first section, for the allowable expenses (before your deductible is met):	
	Out-of-pocket costs (coinsurance) for medical covered benefits. Provide a description of the service received below:
	Out-of-pocket expenses (coinsurance) for covered Pharmacy expenses.