



Group Name \_\_\_\_\_ Member ID# \_\_\_\_\_

Employee Last Name \_\_\_\_\_ First \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Address change (check box if applicable) Phone # \_\_\_\_\_

**Requested Reimbursements** Note: Each item *must* be accompanied by proper documentation. See instructions below.

Item	Patient Name	Date of Service	Relationship to Employee	Service Description	Reimbursement Amount
1					
2					
3					
4					
5					
6					
7					
<b>TOTAL</b>					

**Employee Certification**

I certify that the information above is true and correct; that I have paid the provider of service; that the expenses incurred were for myself, spouse, or qualified dependents; and that I have not been reimbursed and will not seek reimbursement from any other source.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Instructions**

1. Each statement **must** be accompanied by a detailed receipt.
2. Each statement must show the patient name, the date of service, and the amount due.
3. Each receipt must show the amount paid and the specific product or service purchased (for example, a prescription drug).
4. Scan and email form and documentation to: \_\_\_\_\_ or fax form and documentation to **707-525-4223**,

or mail to: **Claims Processing**  
 Redwood Health Services  
 3510 Unocal Place, Ste. 108  
 Santa Rosa, CA 95403

[hscustomerservice@rhs.org](mailto:hscustomerservice@rhs.org)

**Questions?** Call RHS Customer Service at **800-548-7677**, Opt. #2



Redwood Health Services