For PacifiCare Deductible/Full Network Plan Participants

INPATIENT HOSPITAL DEDUCTIBLE REIMBURSEMENT REQUEST FORM

ABOUT THIS FORM – WHAT YOU NEED TO DO

If you have been enrolled in the **PacifiCare Deductible/Full Network plan** since January 1, 2007, you may earn back a portion or all of your calendar year $1,500 inpatient hospital deductible by participating in one or more VEBA-approved health and wellness programs and earning credits. If you become hospitalized, you will be reimbursed up to the number of credits you've earned (to a maximum of the amount you've paid toward your deductible). You will need to submit proof of payment of all or a portion of your inpatient deductible within 365 days of your hospital discharge date before your reimbursement is processed. You will also need to indicate below the programs you have participated in and the amount of reimbursement being requested. Your request will be verified by the plan administrator, and you should receive a reimbursement check within three to four weeks of your request submission.

Please note: Although inpatient hospital deductibles paid for dependents under age 18 will be reimbursed regardless of participation in the health and wellness programs, you must fill out this form and submit proof of payment in order for the reimbursement for a dependent child to be processed.

Please use this form to submit your proof of payment by following these instructions:

1. Complete the information on this form (both pages 1 and 2).
2. Locate the proof of payment from your hospital stay. Examples of proof of payment include:
   - A receipt
   - A hospital bill showing the amount you paid toward your deductible
   - An explanation of benefits showing the amount you paid toward your deductible.

Fax your proof of payment, along with this completed form, to the **VEBA Advocacy Programs** office at (619) 278-0024.

YOU ARE NOT OBLIGATED TO FAX ANY PERSONAL HEALTH INFORMATION. If you prefer, you can mail your completed form to: VEBA Advocacy Programs, 8885 Rio San Diego Drive, Suite 327, San Diego, CA 92108. **To qualify for reimbursement, you must submit this form and proof of payment within 365 days of your hospital discharge date.** Please note that you need to submit only the page(s) of your proof of payment showing the name of the hospital and the amount you paid toward your deductible.

If you have any questions, contact the **VEBA Advocacy Programs**: (619) 278-0021 phone; (619) 278-0024 fax, info@vebaonline.com.

YOUR INFORMATION

Name ____ Number of pages faxed (including this form) _______

PacifiCare member ID# ________________________________ Social Security number _______________________________

Mailing address ____

Daytime phone ______________________________ Email address ____

Amount paid toward inpatient hospital deductible _____________ Date discharged from hospital (mm/dd/yyyy) _________________

YOUR SIGNATURE

By signing this form, I acknowledge that I have paid my inpatient hospital deductible under the PacifiCare Deductible/Full Network plan. I am not covered by any other health insurance plan that will pay the deductible. I understand that if I request reimbursement fraudulently, I will be responsible for paying Southern California Schools VEBA back for the amount I was reimbursed.

Your signature ____ Date ____________________

Check here ☐ if this reimbursement request is for a dependent under age 18 and provide the following information:

Dependent name ____

Social Security number ____________________________ Reimbursement amount requested _______________

Complete the Reimbursement Request Worksheet on page 2 of this form only if you are requesting reimbursement for a member over the age of 18.

FOR OFFICE USE ONLY: DATE______________

Rev. 8/10/07

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REIMBURSEMENT REQUEST WORKSHEET — COMPLETION REQUIRED FOR MEMBERS AGE 18 OR OLDER

Program	**Description**	**Credits Requested**	**Request Reimbursement…**	**Verification**
Value Network Primary Care Physician (PCP) selection	Use a Value Network (non-Scripps Clinic) PCP for a continuous 12-month period	☐ $1,000	After you complete a continuous 12-month period with the same non-Scripps Clinic PCP	PacifiCare
Best Doctors® program participation	Qualify to have your health care case confidentially reviewed by medical experts at Best Doctors	☐ $500	After you sign and submit a service request form to Best Doctors (participation will not be disclosed to PacifiCare or your employer)	Best Doctors
VEBA Weight Loss Challenge participation	Qualify and be selected to participate in the VEBA Weight Loss Challenge	Check only one ☐ $100 (1st six months) ☐ $200 (2nd six months) ☐ $300 (12 months)	After first six months you can submit a request; after second six months you can submit an additional request; or you can submit your request at end of 12-month period	VEBA Advocacy Programs
Health Risk Assessment (HRA) completion	Complete a PacifiCare HRA online at www.pacificare.com	☐ $300	After you fully complete and submit the online HRA (only one completion per 12-month period will be reimbursed)	PacifiCare
Disease management program participation	Participate in a PacifiCare disease management program for six to 12 months. Indicate name of program ___________________________	Check only one ☐ $200 (1st six months) ☐ $300 (2nd six months) ☐ $500 (12 months)	After first six months you can submit a request; after second six months you can submit an additional request; or you can submit your request at end of 12-month period	PacifiCare
PacifiCare VirtualHealthClub℠ participation	Participate in online VirtualHealthClub at www.pacificare.com (e.g., create and monitor a fitness or nutrition plan, dialogue with a coach, review recipes)	Check only one ☐ $200 (1st 10 weeks in a 12-month period) ☐ $20 (each additional week in 12-month period); indicate # of weeks ___________	After first 10 weeks you can submit a request; after each additional week you can submit a request (recommended that you batch multiple additional weeks together)	PacifiCare
Medical group/hospital utilization	Use a particular medical group or hospital when you need hospital services, depending on the group to which your PCP belongs If your PCP is with: • Sharp Rees-Stealy — use Sharp Memorial Hospital • Sharp Mission Park medical groups — use Sharp Memorial Hospital • Scripps Clinic — use Scripps Green Hospital	☐ $500	After hospital services are received (must submit proof of admission if hospital name is not printed on the proof of payment)	PacifiCare
Healthy Pregnancy program participation	Enroll in the PacifiCare Healthy Pregnancy Program (must be pregnant)	☐ $500	After you enroll with PacifiCare either online or by phone	PacifiCare
Another qualified, formalized health-improvement program	If you participate in a formalized health-improvement program for at least six months, your participation may qualify to earn a credit. You will be required to submit a program description and proof of your participation. The VEBA Advocacy Programs office will determine whether the program you participate in qualifies toward earning a credit.	☐ $500	After six months participation (must submit program description and proof of participation)	VEBA Advocacy Programs
Total requested		$_____________		

FOR OFFICE USE ONLY: DATE_______________