SANTA MONICA UNITE-HERE HEALTH BENEFIT FUND

1200 Wilshire Blvd., Fifth Floor.
Los Angeles, CA 90017-1906
(562) 463-5075 •(866)345-5189

MAIL receipts for the purchase of COVID-19 OVER THE COUNTER TEST TO:
Santa Monica UNITE HERE Health Benefit Fund 1200 Wilshire Blvd. 5th Floor Los Angeles, CA. 90017

1. Employee must submit one fully-completed claim form per patient. All questions in Employee Data and Patient Data sections whether claim is employee, employee, spouse, or dependent child MUST be completed.
2. Your completed medical claim form must be submitted along with the itemized receipt for reimbursement.
3. Send completed claim form and related itemized medical bills to claim office address shown above.

I. EMPLOYEE DATA

1. Name (First, Middle & Last)	2. Sex ☐ M ☐ F	3. Date of Birth	4. Social Security Number
5. Home Address Street			7. Employee Status: ☐ Full Time ☐ Leave of Absence ☐ Layoff ☐ COBRA Continuant
City State Zip	6. Last date employee worked before charges for this claim began		

II. PATIENT DATA

8. Patient Name (First, Middle & Last)	9. Birthdate	10. Sex ☐ M ☐ F	11. Relationship ☐ Self ☐ Spouse ☐ Child ☐ Incapacitated Dependent ☐ COBRA Continuant

12. Are natural Parents Divorced or Separated? ☐ Yes ☐ No	13. Do you have custody of the child? ☐ Yes ☐ No	14. Does Natural Parent WITHOUT custody have Financial responsibility for health expenses? ☐ Yes ☐ No	15. Was this parent covered by another Group Medical or Medicare or other governmental plan at the time charges were incurred? ☐ Yes ☐ No

16. Reason for Claim	17. If accident – Please provide date, place and how it happened		
	Date	Place	How it happened
18. Was illness or accident work related? ☐ Yes ☐ No			

III. SPOUSE DATA (Must be completed if claim is for spouse or child)

19. Spouse Name (First, Middle & Last)	20. Spouse's Social Security Number	21. Spouse's Date of Birth
22. Spouse's Employer Name	23. Spouse's Employer Address	24. Spouse's Employer Area Code & Phone No. ( )

Employee Signature	Date	Patient's Signature (Parent if minor)	Date

DO NOT WRITE IN SPACE BELOW

Control No.	Acct No.	Plan Name	Verified By