Pinnacle HEALTH SOLUTIONS

Reimbursement request form

INSTRUCTIONS
To process your reimbursement request, this form must be fully completed, signed, and returned with all required documents. You must attach a copy of your receipt that shows the dollar amount of your request, when the service occurred, and when it was paid. Please allow up to 30 days for review and processing after you submit your request for reimbursement.

Please submit to:
Mail: Pinnacle Health Solutions
P.O. Box 2220
Newport Beach, CA 92658

Email: **GSFWorkingspouseprogram@pinnacle-health.com**

Employee Information

Name:	Facility:	Phone Number:
Address:		
City:	State:	Postal Code:
Is this a new address? ☐ Yes ☐ No		

Expense Information (please see the back of this form for a description of expense types.)

Type of Expense	Patient Name	Date of Service	Health Plan Carrier/ Service Provider	Amount
☐ Out Of Pocket Medical Expenses				
☐ Out Of Pocket Medical Expenses				
☐ Out Of Pocket Medical Expenses				
☐ Out Of Pocket Medical Expenses				
☐ Out Of Pocket Medical Expenses				
☐ Out Of Pocket Medical Expenses				
☐ Out Of Pocket Medical Expenses				
			Total Expenses:	

Sign and acknowledge

I attest that the information contained in this Request for Reimbursement is true and accurate. I am an eligible participant in the WSP program, enrolled in a health plan, and seeking reimbursement for a medical health care service covered under my health plan. I understand that if I provide incomplete, false or misleading information, my Request for Reimbursement may be delayed or denied. I agree to indemnify and hold Pinnacle Health Solutions harmless from any liability for payment of benefi ts made based upon any of information that is inaccurate or false and to repay any benefi ts that I incorrectly received.

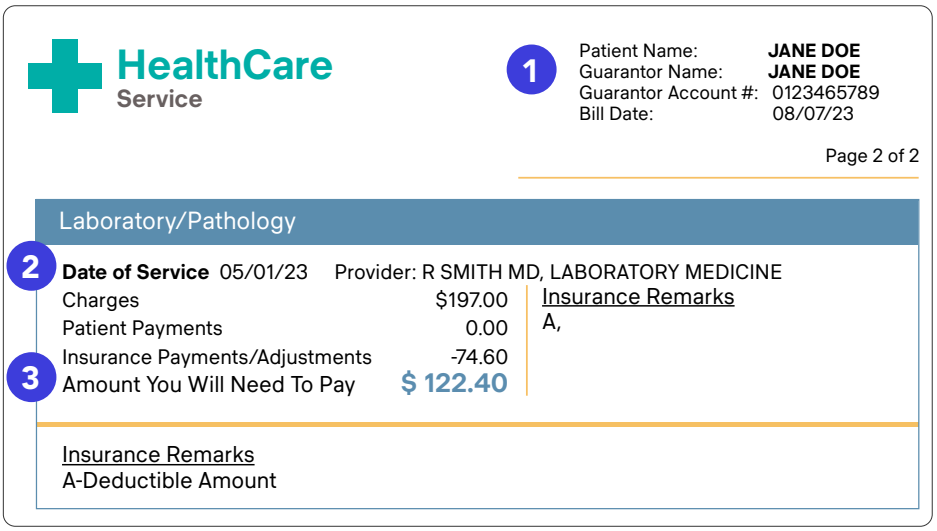
Signature:	Date: MM | DD | YYYY

gsf | golden state foods

ACCEPTABLE RECEIPT CRITERIA

1. Patient name must be listed to associate the document with person seeking reimbursement.
2. Date of service must be listed and in the current plan year
3. Patient responsibility (copay, coinsurance, deductible)/goods purchased (Rx, medical equipment, etc.) must be listed on the documentation/receipt, and dated in the current plan year
4. Amount paid for the service or transaction.
5. If an Explanation of Beneits (EOB) is provided, it must also include the name of person receiving goods/services

Example:



REIMBURSABLE EXPENSE TYPE

Out-of-Pocket Medical Expenses:

Your share of medical costs after your Health Plan pays its portion of expenses. Out-of-pocket costs include coinsurance, copayments, and deductibles. This amount will never include an amount that exceeds the covered charge for out-of-network providers (also called "balance-billed charges") or health care expenses that aren't covered on your health plan.