MARIN BENEFITS & INSURANCE SERVICES

SFHCSO CLAIM REIMBURSEMENT FORM

How to Submit Your Claim

By Fax (415) 454-2928

By Mail 700 Larkspur Landing Circle, Suite 199
Larkspur, CA 94939

Questions?

Customer Service (415) 526-1401

Email helpdesk@marinbenefits.com

Member Information

Name (Last, First, Middle Initial)

E-Mail Address

Address (Street)

Phone Number

Address (City, State, Zip)

❑ **Check Here If New Address**
Demographic changes will be verified with HR

Healthcare Expense Claims

Date	Patient Name	Provider Name	Description	Amount
			Total Healthcare Expense Claims	**$**

Attach copies of appropriate receipt(s) and submit with this claim form.

Signature of Member

By signing below I certify that my statements on this form are true and accurate. I certify that all expenses for which reimbursement is claimed were incurred for myself and not for my dependents. I certify that the medical expenses claimed are not covered by insurance and cannot be reimbursed under any other health plan coverage. I further understand that reimbursed expenses cannot be claimed as a credit on my personal income tax return.

Signature

Date

Reimbursements are made by check only. Please allow 2-6 weeks for processing and payment of your reimbursement.
Failure to provide appropriate documentation will result in delays in the processing of your claim.