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EUTF Supplemental Medical & Prescription Drug Plan

EUTF Claim Submission Form

ATTENTION	**The plan year is from July 1, 2023 to June 30, 2024.** The filing deadline for dates of service between July 1, 2023 and June 30, 2024 is December 27, 2024 or 180 days after your termination date, whichever is earlier. The plan will not pay any claims received after the filing deadline.

PLEASE NOTE: To ensure proper posting, please use a separate claim form for each covered member and for services incurred in different plan years.

Please follow the Claim Filing Requirements on the back of this form. Complete the information below for medical care and/or prescription drug expenses that were incurred by you or your covered dependents. The services must have been paid by your primary health insurance plan to be eligible for reimbursement. Failure to complete this form or follow the Claim Filing Requirements will result in a delay in processing your claim.

Employee Name: _____ (First Name) _____ (Last Name) _____ (MI)

Phone Number: _____ **Email Address:** _____

	Date of Service/Rx Filled Date	Name of Person Receiving Service	Date of Birth	Description of Service	Amount
1					$
2					$
3					$
4					$
5					$
6					$
				Total Requested Reimbursement Amount	$

To the best of my knowledge, the information on this Claim Form is complete and true. I certify that these are eligible medical care and/or prescription drug expenses that my dependents or I have incurred. I understand that these expenses must qualify as benefits under the EUTF Supplemental Medical & Prescription Drug Plan, and cannot be reimbursed by any other source or used as a deduction on my personal income tax return. I have read and followed the claim filing requirements on the back of this form.

☐ I have attached receipts or documents in support of these services.

Employee's Signature: _____ **Date:** _____

For Official Use Only

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EUTF Claim Filing Requirements

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PLEASE NOTE: Failure to complete the Claim Form or follow the Claim Filing Requirements will result in a delay in processing or denial of your claim. To ensure proper posting, please use a separate claim form for each covered member and for services incurred in different plan years.

For Claim Submissions

To expedite the claim submission process, we strongly recommend submitting all claims online.

1) **Visit www.verdegard-hi.com/eutf and select the "File a Claim" button.**

2) **Complete all the information requested on the claim form.**

3) **For reimbursement of medical services,** please attach your primary health insurance payment report (e.g., HMSA Report to Member (RTM), Kaiser Permanente Bill of Service statement, or Explanation of Benefits (EOB)). If you also have Medicare or Med-QUEST coverage, please attach your Medicare or Med-QUEST EOB as well.

   Please Note: Billing statements and payment receipts from your healthcare provider will not be accepted.

4) **For reimbursement of prescription drugs**, please attach pharmacy payment reports or prescription drug receipts and labels from your pharmacy that show the patient's name, physician's name, Rx number, drug name, date of service/filled date, quantity/days supply, and amount of copayment.

5) **For paper claim submissions only, please sign and date the claim form**.
   Mail or fax a completed claim form and all supporting documents to:

   Verdegard Administrators, LLC
   ATTN: Claims Department
   P.O. Box 135005
   Honolulu, Hawaii 96801-5005
   Fax: (808) 951-4620

   Please Note: Be sure to submit a photocopy of your claim form and supporting documents. Any documents submitted to Verdegard Administrators, LLC for processing will not be returned. Additional claim forms can be downloaded online at www.verdegard-hi.com/eutf.