

**Santa Monica Community College District  
FACULTY ASSOCIATION MEDICAL EXPENSE REIMBURSEMENT WORKSHEET**

Last Name:	First Name:	Date:	Amount Approved:	
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**Complete this WORKSHEET FOR OUT-of-POCKET MEDICALLY ELIGIBLE EXPENSES**

Use the attached "Comparison of PERSCare and PERS Choice" for the Plan Year for which you are submitting claim form to determine applicable reimbursement categories.  
(i.e., Use the Comparison of PERSCare to PERS Choice for the Plan Year 2017/2018 for reimbursements of out-of-pocket expenses incurred from Jan. 01, 2016 through Dec. 31, 2016/Jan. 01, 2017 through Dec. 31, 2017 )

Item #	Benefit Category (use drop down list- categories found on "Comparison of PERSCare vs Choice")	Date of Service (dd/mm/yy)	Patient Name	Provider Name	In-Network Provider (use drop down list)	Visit # (If applicable, enter the visit number for this date of service)	# of Days (If applicable, enter the day number for this date of service)	Other (use page 2 for explanation)	Copay Amt Paid (If applicable)	Out-of-Pocket Amount Paid (If applicable; not including copay)	PERSCare Member Amt (If applicable; not including copay)	PPO Choice Member Amt (If applicable; not including copay)	% NOT Covered by Choice (If applicable; not including copay)	Total Amt Requested for Reimbursement	HR Use Only		
															Item Approved by SMC (Yes/No)	Amount Denied by SMC	Amount Approved by SMC
	Column1	Column2	Column3	Column4	Column5	Column6	Column7	Column8	Column9	Column10	Column11	Column12	Column13	Column14	Column15	Column16	Column17
1														\$0.00			
2														\$0.00			
3														\$0.00			
4														\$0.00			
5														\$0.00			
6														\$0.00			
7														\$0.00			
8														\$0.00			
9														\$0.00			
10														\$0.00			
11														\$0.00			
12														\$0.00			
13														\$0.00			
14														\$0.00			
15														\$0.00			
16														\$0.00			
17														\$0.00			
18														\$0.00			
<b>TOTALS:</b>								\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		\$0.00			\$0.00

Deduct out-of-pocket expense in excess \$250.00	
<b>Grand Total:</b>	