Office of Human Resources

Request for Medicare Part B Reimbursement (Quarterly or Annual)

Instructions: Complete this form to request reimbursement for Medicare Part B payments on a quarterly or annual basis. Eligibility requirements include: 1) must be a retiree or spouse of the Contra Costa Community College District (CCCCD) and 2) must be enrolled in a District sponsored Medicare plan during the timeframe of the request for Medicare Part B reimbursement. **Please Note:** This Medicare Part B reimbursement form is available throughout the year at the District website. Go to www.4cd.edu select "Human Resources," "Benefits," and "Retirees."

Retiree First and Last Name		**Spouse First and Last Name (if applicable)**
Retiree - Social Security #	**Retirement Date**	**Spouse - Social Security Number (if applicable)**

Mailing Address	**City**	**Zip Code**	**Phone Number**

MEDICARE PART B PREMIUM REIMBURSEMENT FOR THE CALENDAR YEAR	
(√) **Check One**	**I have enclosed one of the following documents for reimbursement verification:**
☐	Social Security statement showing the amount of the monthly Medicare Part B premium deduction and when the payments will begin. The form and documentation needs to be submitted to the reimbursement vendor below every January or anytime the premium amount changes.
☐	Medicare quarterly billing statement and proof of payment. The form and documentation needs to be submitted to the reimbursement vendor below every January or anytime the premium amount changes.
☐	A copy of the monthly Cal STRS statement(s) indicating Medicare Part B premiums deducted from your Cal STRS retirement check. The form and documentation needs to be submitted to the reimbursement vendor below every January or anytime the premium amount changes.
☐	A copy of Form SSA-1099 from Social Security which indicates the Medicare B premium payments for the previous calendar year.

Submit to	Navia Benefit Solutions - Email: 105@naviabenefits.com, Fax: (866) 831-6222, Mail: PO Box 53250, Bellevue, WA 98015
Questions	Navia Benefit Solutions - Phone: (866) 897-1996, Email: 105@naviabenefits.com
Deadline	Claims must be submitted no later than December 31st for the previous calendar year. For example 2022 claims must be submitted by 12/31/2023
	Reimbursements are issued weekly on Friday. Reimbursements will be directly deposited into your bank account or a check mailed to your home. Direct deposit may take 1-2 days to post to your bank account.

Current Plan	☐ Kaiser Senior Advantage	☐ Kaiser HMO	☐ Anthem Medicare	☐ Anthem PPO
Retired	☐ United Faculty	☐ Local 1	☐ Management Council	☐ Surviving Spouse
Request	☐ Quarterly Reimbursement	OR	☐ Annual Reimbursement	

I certify that I: 1) am a retiree of CCCCD or a surviving spouse of a retiree, 2) am enrolled in a qualifying Medicare coordinated plan through CCCCD and 3) am requesting Medicare Part B reimbursement on a quarterly or annual basis. Surviving spouses are ONLY eligible for Medicare Part B reimbursement for 6 months following the date of death of the retiree. I certify the information provided is accurate and if there is a change in this status, I will notify the District. I understand that I am solely responsible for the sufficiency, accuracy, and veracity of claims and all information related to these claims submitted to my health reimbursement arrangement ("HRA") and that unless an expense for which payment or reimbursement is claimed is a qualifying expense under such benefit, I may be liable for the entire amount reimbursed or payment of all related taxes including federal, state, or city income tax on any reimbursement issued hereunder. I am claiming health care reimbursement for eligible medical care expenses incurred by myself, spouse, and/or dependents during the plan year shown above and certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance. Note: The IRS does not recognize Domestic Partners for purposes of receiving tax-favored health benefits. For further information, please contact your employer. Finally, I understand and have reviewed Navia's website privacy policy, privacy notice, and the website terms and conditions. I consent to the use and disclosure of my information in accordance with Navia's online policies and consistent with applicable law solely for the purposes of administering my benefits as outline in the agreement between my employer and Navia. By providing an email address, I consent to receive all possible communications from Navia, agents, and subcontractors regarding the Plan via email. I may withdraw consent at any time without charge by contacting Navia by phone, email, or mail. To update your email address contact Navia by phone, email, or mail. You have the right to receive paper version of an electronic document free of charge. Software requirements will be provided with each electronic document. I hereby authorize my benefits to be reduced by the amount(s) claimed above.

Retiree or Surviving Spouse Signature	**Date**