

If you are charged for Medicare part D premiums, use this form to request a reimbursement from OUHSD



## Medicare Part D Reimbursement Form

<b>Name</b>		<b>Date</b>	
<b>Street Address</b>		<b>City, State &amp; Zip</b>	
<b>Phone Number</b>		<b>Email Address</b>	

<b>Dates of Service</b>	<b>Details</b>	<b>Amount</b>
	Medicare Part D Reimbursement	
	Medicare Part D Reimbursement	
	Medicare Part D Reimbursement	
	Medicare Part D Reimbursement	
	Medicare Part D Reimbursement	
	Medicare Part D Reimbursement	
<b>Total amount owing</b>		

<b>Signature</b>	<b>Date</b>
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Please attach a copy of your Medicare Part D statement or annual letter. Reimbursements will be issued within 10 business days of receipt of the completed reimbursement form and required documents.

Please submit reimbursement no less than twice each year.

**Submit form and attachment(s) to:**

**Oxnard Union High School District**  
**Accounts Payable**  
**1800 Solar Drive**  
**Oxnard, California 93030**