University of California
San Francisco

School of Pharmacy

Office of Student
& Curricular Affairs
School of Pharmacy
San Francisco, CA
94143-0150
tel: 415/476-2733
fax: 415/476-6805

C O - P A Y / D E D U C T I B L E R E I M B U R S E M E N T

Name	
Social Security #	
Telephone	
Address Indicate where you want your check sent	
E-mail Address	

Co-Pay reimbursement ($75.00 max/year): provide the requested information for each co-pay:

Physician's Name	Date of Charges	Amount
Example: Brown	*5-1-2002*	*$10.00*

Deductible reimbursement ($200 max/year; GSHIP covered students only):

Physician's Name	Date of Charges	Amount
Example: Brown	*5-1-2002*	*$10.00*

For each co-pay or deductible reimbursement, you must also include a photocopy of the proof of payment—typically a receipt or cancelled check or credit card statement. (Statements showing the amount of the co-pay are not sufficient.) Do not send originals—keep them until you have received your reimbursement check. If your proof of payment is a check, please provide a photocopy of both the front and back of the cancelled check. If you are requesting reimbursement toward the GSHIP deductible, you must also include a copy of the Explanation of Benefits statement from the insurance company. Any information related to your condition should be blacked out.

Submit this form and the photocopies by mail to **Lucia Piriano**, School of Pharmacy, 513 Parnassus Ave., #S-960, S.F., CA 94143. For questions regarding reimbursement, contact Lucia at 415-502-5373 or at pirianol@pharmacy.ucsf.edu.

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