IMPERIAL VALLEY COLLEGE

Retirees' Prescription Reimbursement Progam

Retiree Name: **Complete Mailing Address:**	**Date of Claim Submission:**

LEGIBLE RECEIPTS THAT INCLUDE RETIREE NAME, DATE AND TYPE OF MEDICATION OR PRESCRIPTION MUST BE ATTACHED TO AUTHORIZE REIMBURSEMENT.

WCA USE ONLY	NAME OF DRUG OR MEDICATION	DATE PRESCRIPTION FILLED	RETIREE PORTION ONLY	WCA USE ONLY
			$	
			$	
			$	
			$	
			$	
			$	
			$	
			$	
			$	
			$	
		TOTAL:	$	

By signing below, I affirm the accuracy of this claim for reimbursement, including my eligibility and the amount of out-of-pocket expense incurred by me.

Submit Claims By Fax To:
(619) 232-4440

Signature of Retiree

For WCA Use Only:
Ck No.:
Date of Reimbursement:
Script Fee:

Or By Mail To:

WEST COAST ADMINISTRATORS, INC.
444 West C Street, Suite 350
San Diego, CA 92101-3582

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