

Reimbursement Form

Living Well with Chronic Conditions

Sponsoring Organization: _____

Workshop Dates: _____

Contact Person: _____

Phone #: _____

Leader Name (1): _____

Leader Name (2): _____

Oregon Medical Insurance Pool (OMIP) Member Information (**reimbursement will be made directly to the member**):

Name: _____

Address: _____

Phone #: _____

This member attended ____ out of 6 workshops (must attend 4 out of 6 workshops to receive reimbursement from OMIP).

Cost of the completed workshop: \$_____

Submit reimbursement form to:
Regence BlueCross BlueShield of Oregon
Attn: Jonathan Shelton
Mailstop E9B
PO Box 1271
Portland, OR 97207

Questions? Contact Regence at **1-866-543-5765**.

(Date)

(Signature of Trainer)