Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust

INSTRUCTIONS FOR FILING CLAIMS UNDER HEALTH REIMBURSEMENT ACCOUNT

Please read this before submitting your Claim Form for Reimbursement of an Out of Pocket Expense.

GENERAL RULES

- You must certify that the information on the Claim Form is accurate and complete.
- ***You must request the reimbursement of eligible medical expenses which were incurred ONLY on your own behalf or on behalf of one of your eligible dependent(s).***
- With regard to eligible medical expenses, you must have already received the products or services.
- Finally, you CANNOT have received payment or reimbursement of the expense from any other plan or party and MUST NOT seek such reimbursement for the same products or services which are reimbursed under this Benefit Trust.

You cannot receive a cash-out or lump sum payment from this HRA. It is ONLY available for reimbursement of eligible medical expenses which you owe or already paid out of pocket OR to pay Self-Payment or Retiree Premiums to the Benefit Trust to maintain eligibility for yourself and your family.

TIPS FOR FILLING OUT YOUR CLAIM FORM

- The **Participant** is the only person authorized to file this Claim Form, so the **Participant** must sign the Claim Form. If you are a surviving spouse or surviving dependent who has a HRA due to the death of a Participant, you are eligible to file this Claim Form on your own behalf.
- If you have more than six items to reimburse at this time, please file more than one form. Do not just attach supplemental sheets of paper.
- You must provide the total request amount at the bottom of the Claim Form. Please make sure that your reimbursement requests total at least $25.00 with the exception of the final balance remaining in the HRA, in which case the requested payment amount must be the entire balance.

THINGS TO REMEMBER WHEN INCLUDING RECEIPTS

- All medical receipts should be accompanied by the Anthem or other insurance company's explanation of benefits (EOB). You may go to www.anthem.com to print medical claims details for submission.
- Prescription receipts must have the patient's name, date of service, the drug name and drug cost printed by the pharmacy.
- Each medical expense must show the date of service, patient name, type of service and the provider's name and address. Handwritten receipts are not acceptable without an EOB.
- A cancelled check, cash register receipt or credit card receipt is not acceptable.
- Submission of orthodontics claims must be accompanied by the original contractual agreement.
- You should keep the original receipts and invoices in case of an IRS audit.
- Circle the dollar amount that is being claimed on each submitted out of pocket cost.

As always, if you have any questions regarding your HRA or filing of this claim for reimbursement, please contact the Benefit Trust Office.

Iron Workers District Council of Southern Ohio and Vicinity Benefit Trust

HEALTH REIMBURSEMENT ACCOUNT CLAIM FORM
OUT OF POCKET EXPENSES

Fax or Mail Claim Form to: *Iron Workers Benefit Trust*
Main PO Box 398 – Dayton, OH 45401-0398
Fax: 937-454-5457 (Be sure to send fax printed side up)

Participant Name (Print) Date of Birth

Social Security No./Health ID No. Phone No.

Address City, State, Zip

Certification:

I certify that the information on this form is accurate and complete. ***I am requesting reimbursement of eligible medical expenses which were incurred by myself or my eligible dependent(s).*** With regard to eligible medical expenses, I certify that I have already received these products or services, have submitted them for coverage through all available insurances, and have not and *will not* seek reimbursement of this expense from any other plan or party.

Participant Signature Date

Date of Service	Name of Service Provider	Describe Expense	Patient Name or Self	Out-of-Pocket Cost*

Total amount of requested reimbursement:
(Must be equal to or greater than $25.00) ______________

See reverse side for detailed claims filing instructions.

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