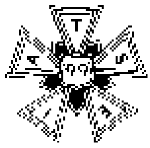

I.A.T.S.E. LOCAL 99
HEALTH FUND PLAN
230 West 200 South Suite 2110
SALT LAKE CITY, UT 84101
Phone: (801) 363-0815
Fax: (801) 363-0815

For department use only.

CLAIM #______________
RECEIVED____________
NOTIFIED_____________
SATISFIED____________

Claim Form

To receive your check, you must follow all of the instructions on the back of this form. Use one Claim Form for each "patient" you are requesting reimbursement for.

PARTICIPANT'S INFORMATION

Name ____ Date __________________________

Social Security Number __________________________________ Date of Birth ____________________

Phone Number ____________________________ Pager / Mobile Number _______________________

Address ____

City ____________________________________ State _______ Zip Code _____________________

PATIENT'S INFORMATION

Name ____ Relation _______________________

Social Security Number __________________________________ Date of Birth ____________________

EXPENSES

Total

1. ____
2. ____
3. ____
4. ____
5. ____

O Check to payout what is in account and close claim. **Page Total** ________________

Warning

Any person who knowingly and with intent to defraud files a statement of claim containing any material false information, or conceals for the purpose of misleading information concerning any fact material there to, commits a fraudulent act, which is a crime punishable by fine, imprisonment, or both.

By signing below, I hereby certify that

(1) The above information is true and correct.
(2) The amounts I am claiming as reimbursable for health care have not been reimbursed and are not reimbursable through any insurance or other benefit plan.
(3) I understand that the reimbursed expenses cannot be claimed as an income tax deduction.
(4) I authorize any insurance company, prepayment organization, employer, hospital or provider to release all information with respect to myself or any of my dependents which may have bearing on the benefits payable under this or any other plan providing benefits or services.
(5) I certify that any person other than myself is my dependent or spouse.
(6) Effective January 1, 2017 there will be a 2% fee assed on all reimbursement claims.

Signature____

- I N S T R U C T I O N S -

In order to receive a Health Fund Plan benefit, check you must:

1. Fill out the front of this sheet completely.
2. Attach copies of your **LEGITIMATE MEDICAL EXPENSES** to this sheet.
3. Have submitted a signed **"ENROLLMENT FORM"**.
4. Mail or deliver this form and all supporting paperwork to Local 99 Health Fund Plan
   230 West 200 South Suite 2110, Salt Lake City, UT 84101
5. Show proof of other coverage, either, VA coverage, Medicaid, Medicare, Self-Insured policy, or a Healthcare.gov plan.

Invoices or payment receipts are acceptable proof of a legitimate medical expense. They must include:

1. **Name address and telephone number of Doctor or service provider.**
2. **Name of person receiving services.**
3. **Date(s) services were performed.**
4. **Massage therapy is only reimbursable if done pursuant to a doctor's prescription. The Prescription must be included with any request for reimbursement.**
5. **Only expenses recognized under IRS section 213 will be reimbursed. Refer to "ALLOWED EXPENSES" for a listing of these expenses.**

Copies of checks or check carbons are not acceptable proof of a legitimate medical expense.

Prescription receipts must have the Pharmacy attachment. Store receipts are not enough.

Claims will be processed at our earliest opportunity. If you feel too much time has elapsed contact us.

Please direct all problems and questions to Laura Smith, Assistant Benefit Coordinator at (801) 363-0815. Direct Appeals to Dan Hutten, Administrative Manager at (801) 232-1158.

Thank You.