I.A.T.S.E. LOCAL 99
HEALTH FUND PLAN

2598 South Park Street
SALT LAKE CITY, UT 84106
Phone: (801) 363-0815
Temp Phone 801-450-0054

Example of a claim

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 John Doe Date 4/15/2022

Social Security Number 111-11-1111 Date of Birth 12/1/1959

Phone Number 801-555-5555 Pager / Mobile Number 801-555-5555

Address 1234 Happy lane

City Salt Lake City State UT Zip Code 84111

PATIENT'S INFORMATION

Name John Doe Relation Self

Social Security Number 111-11-1111 Date of Birth 12/1/1959

EXPENSES

Total

1. If adding a bill for spouse please provide there name, social, date of birth, relationship to you
2. Jane Doe
3. 10/1/1956
4. 222-22-2222
5. Spouse

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 orspouse.
(6) Effective January 1, 2017 there will be a 2% fee assed on all reimbursement claims.

JOHN DOE

Signature____________________

:xpense Report

Customer Statement Report
Date Range: 2021-09-07 to 2022-03-07

Patient: John/Jane Doe
Date of Birth: 12/01/1959
Address: 1234 happy lane

SALT LAKE CITY, UT
84111

Statement prepared at: kroger.com

Fill Date	RX #	Drug Name	NDC #	Qty	Days Supply	Prescriber Name	Insurer(s)	TP Auth #	Insurance Amount	Patient Responsibility	Total Amt
02/25/2022	70600137-7147533	RX NAME	27241-0124-03	60	12	Doc Smith	Goodrx Discount Card	HN46546546546MDTLC	-	$12.87	$12.87
02/25/2022	70600137-2719785	RX Name	00406-0523-01	60	15	Doc Smith	Goodrx Discount Card	53978546546546042022556	-	$20.63	$20.63
02/21/2022	70600137-4880451	RX Name Tablet	50228-0109-01	90	30	Doc Smith	Goodrx Discount Card	220514654654393002003999	-	$8.71	$8.71
02/12/2022	70600137-7135262	RX Name	68180-0638-09	30	30	Doc Smith	Cigna Card	87946546463803202066G	-	$12.25	$12.25
02/12/2022	70600137-7135262	RX Name	68180-0638-09	30	30	Doc Smith Match	Goodrx Discount Card	87938054654654632020660		$12.25	$12.25
01/25/2022	70600137-2718501	RX Name Tab	00406-0523-01	60	15	Doc Smith	Goodrx Discount Card	546565465465465453920125 1G		$20.63	$20.63

Tooth DR
3258 same name

Salt Lake City, UT 84111
(801)55-5555

STATEMENT

03/04/2022
Account Number

John Jane
Doe
1234 happy lane
SALT LAKE CITY,
UT 84111

Total:	$280.00
-Ins Estimate:	$270.00
=Balance:	$10.00

Date	Patient	Code	Tooth	Description	Charges	Credits	Balance
				Balance Forward			0.00
03/04/2022	Jane	D0140		limited oral evaluation - problem focused	80.00		80.00
03/04/2022	Jane	D0220		intraoral - periapical first radiographic image	30.00		110.00
03/04/2022	Jane	D4341		LR- periodontal scaling and root planing - four or more teeth per quadrant	250.00		360.00
03/04/2022	John	PERIO		Periodontal Candidate (No Bill Ins)	0.00		360.00
03/04/2022	John	Pay		Cash $80.00		80.00	280.00
03/04/2022	John	Claim		Pri Claim $360.00 TDA Waiting to Send Estimated Payment Pending: $55.00 Writeoff: $215.00 Est. Patient Portion: $90.00			

FASHION FRAMES * CONTACT LENSES
PRESCRIPTION LENSES

ONLINE SHOPPING: COSTCO.COM

Tax ID#: 91-1223280. Costco Wholesale does not accept assignment.
Please forward reimbursements directly to the Costco member at address below.

INVOICE DATE	INVOICE NO.	PROFILE NO.	MEMBER NO.
11/05/21	10004245899 2022	0002123165466703879	

OPTICAL DEPT.
113 SALT LAKE CITY
1818 S 300 W
SALT LAKE CITY, UT 84115
801 485-9757

PATIENT
Doe, Jane
1234 Happy road
Salt Lake city UT 84111

PRESCRIBING DOCTOR	Rx WRITTEN	Rx EXPIRES	OPTICIAN	CASE
Doc Smithl	11/05/21	11/05/23	AV	

CONTACT LENSES

	BC1	DIA.	POWER
R	8.60	14.20	-4.50
L	8.60	14.20	-4.50

COLOR: (R) 2 NO COLOR
(L) 2 NO COLOR

SPECIAL INSTRUCTIONS
OWE ALL WILL PICK UP IN STORE

	QTY	ITEM	DESCRIPTION	UNIT PRICE	EXTENSION
R	2	1488170	Infuse 90pk	89.87	179.74
L	2	1488170	Infuse 90pk	89.87	179.74
				TAX:	27.86
				TOTAL:	387.34

SLIP PRINT
SLIP PRINT RECEIPT NPI: 1285021654654S549
MEMBER #:

OPTICAL ORDER # 0#2363653865796
#1

2 @ 89.87		
F	1488170 INFUSE 90PK	179.74 A
2 @ 89.87		
F	1488170 INFUSE 90PK	179.74 A
	0000241201 /1488170	40.00-A
	SUBTOTAL	319.48
	TAX	24.76
****	TOTAL	344.24
	FSA ITEM TOTAL	359.48
	FSA COUPON TOTAL	40.00-
	FSA TAX TOTAL	24.76
	FSA TOTAL	344.24
	MasterCard	344.24 F
	CHANGE	0.00
A 7.75% TAX		24.76
TOTAL TAX		24.76
TOTAL NUMBER OF ITEMS SOLD =		4
INSTANT SAVINGS		$ 40.00

** Exclusive to Costco Members **
You can now purchase contact lenses and sunglasses at Costco.com
Valid prescription required for all contact lens purchases.

PATIENT COPY

127 South 500 East, Suite 100
Salt Lake City, UT 84102-1959

Keep this statement. This is the financial documentation of your medical visits.

John Doe
1234 Happy Road
Salt Lake City UT 84111 USA

Patient: John Doe
Responsible Party: John Doe
Statement Date: 10/18/21

New Account Balance	**$555.38**
Minimum Amount Due	**$75.00**
Date Due	**11/08/21**

Please pay the minimum due by the due date above to keep your account current (note that payments, such as co-pays, made for new visits are not applied towards your minimum amount due). **If you are in need of financial assistance due to COVID-19, please contact our Financial Advocates at (801) 581-2957 option 3.**

PAY ONLINE
uofuhealth.org/mychart

PAY BY PHONE
801.587.6303

PAY BY MAIL
PO Box 841482
Los Angeles CA 90084-1482

Account Number

ONLINE PAYMENT OPTIONS
+ LOG IN AS A GUEST
Make a payment without MyChart
Guarantor Account Number: xxxxxx
Name:Doe
UofUHealth.org/GuestPay

FOR QUESTIONS OR TO SET UP A PAYMENT ARRANGEMENT:
Call 801.587.6303 or 800.862.4937
E-mail billing@healthcare.utah.edu
Schedule an Online Billing Consult

FOR HELP UNDERSTANDING YOUR STATEMENT:
Visit healthcare.utah.edu/bill

Make checks and money orders payable to:
University of Utah Health

ACCOUNT STATEMENT
ACCOUNT #

Thank you for selecting
University of Utah Health
healthcare.utah.edu

Please return this portion with your check or money order.

If you would like to pay with a credit card, please visit us online www.healthcare.utah.edu/bill or call us at 801-587-6303.
Please note that our return address for payments has changed.

STATEMENT DATE: **10/18/21**
ACCOUNT BAL: **$555.38**

DATE DUE: **11/08/21**
AMT PAID: $

STATEMENT DETAIL
Account #

Statement Date
10/18/21 Page 3

VISIT DETAILS

Please allow 30 days for new transactions (payments, charges, etc.) to appear on statement.

Date	Description	Charges	Pmts/Adjs	Insurance Balance	Patient Balance
Professional Visit #106131546541631 University Hospital Main Operating Room Outpatient - **Date of Service: 09/15/21 - 09/15/21** Primary Insurance: BLUE CROSS BLUE SHIELD					
Provider: Doc Smith, MD - GENERAL SURGERY					
09/15/21	Repair H patient age 5 years or older	$1,783.40			
10/18/21	BLUE CROSS BLUE SHIELD INSURANCE PAYMENT Deductible: $412.04 Coinsurance: $55.38		$498.43		
10/18/21	BLUE CROSS BLUE SHIELD INSURANCE CONTRACTUAL		$817.55		
	Visit Total	$1,783.40	$1,315.98	$0.00	$467.42
Professional Visit #106565465413943 University Hospital Radiology Outpatient - **Date of Service: 09/15/21 - 09/15/21** Primary Insurance: BLUE CROSS BLUE SHIELD					
Provider: RDoc Smith, MD - RADIOLOGY					
09/15/21	Ultrasound of scrotum	$75.65			
09/15/21	Ultrasound limited	$149.07			
10/18/21	BLUE CROSS BLUE SHIELD INSURANCE PAYMENT Deductible: $87.96		$0.00		
09/27/21	BLUE CROSS BLUE SHIELD ADJUSTMENT		$75.65		
10/18/21	BLUE CROSS BLUE SHIELD INSURANCE CONTRACTUAL		$61.11		
	Visit Total	$224.72	$136.76	$0.00	$87.96
	Totals	**$2,008.12**	**$1,452.74**	**$0.00**	**$555.38**
	Balance Due				**$555.38**