



Mail this form to:

IATSE National Health & Welfare Fund
Medical Reimbursement Claims Unit
417 Fifth Avenue, Third Floor
New York, New York 10016-2204

E-mail this form to: psc@iatsenbf.org

Upload via website: www.iatsenbf.org

IATSE National Health & Welfare Fund Plan C Medical Reimbursement Program (MRP) Claim Form

Claim filing instructions:

1. Please print legibly and complete all sections on this form, front and back
 2. Please read both sides of this form before sending in your claim
 3. For reimbursement of a dependent's expenses: Such dependent MUST be enrolled in a group health plan that provides minimum value. You must complete a separate reimbursement form for each dependent. (This form must only include expenses incurred by the patient listed below.)
 4. Along with this form you must include all supporting documentation, as applicable, such as:
 - a. another group health plan's explanation of benefits
 - b. an itemized bill or receipt from the provider
 - c. another group health plan's premium statement along with your proof of payment such as a cancelled check (only premiums that you paid with post-tax money may be reimbursed)
 - d. The claim number from your original claim if you are responding to an information request from the Fund
 5. Check our website, www.iatsenbf.org, to ensure your address is up to date, all your covered family members are properly listed and select direct deposit for faster payment receipt
 6. Refer to your MRP Guidebook for the list of reimbursable items and the Summary Plan Description for further filing requirements beginning on page #24

| | | | | |
|---|------------------------------------|---|--|---------------------|
| Participant Name: | | | | |
| <i>Last</i> | <i>First</i> | <i>M.I.</i> | | |
| Johnson | Michael | | | |
| Your Participant ID # or SSN: | | Male <input checked="" type="checkbox"/> | Female <input type="checkbox"/> | |
| Your Date of Birth: 123-45-6789 | | X | | |
| <i>Address:</i> | <i>Month</i> 03 | <i>Day</i> 15 | <i>Year</i> 1985 | |
| Telephone #: 742-555-1234 | <i>Street</i> Evergreen Terrace | <i>City</i> Springfield | <i>State</i> IL | <i>Zip</i> 62701 |
| Name of other group health plan coverage: 555-123-4567 | | mjohnson@email.com | | |
| Patient Name: | | | | |
| <i>Last</i> | <i>First</i> | <i>M.I.</i> | | |
| Johnson | Michael | | R | |
| Patient's relationship to you: Self | | | | |
| <i>Month</i> 03 | <i>Day</i> 15 | <i>Year</i> 1985 | | |
| <p>Please note that all claims for reimbursement must be received by the Fund within 12 months of the date of service or the date the premium is paid (in the case of a request for premium reimbursement). In addition, you (or your dependent, as applicable) must have been enrolled in the Plan C MRP option on the date of the service (or the date the premium was paid, as applicable) and at the time the reimbursement is submitted to the Fund.</p> | | | | |

List all items you are requesting reimbursement for:

| Name of Provider of Service | Dates of Service(s) / Period being claimed | Total Charges being claimed for reimbursement |
|-----------------------------|--|---|
| City Medical Center | 12/15/2025 | \$150.00 |
| Downtown Pharmacy | 12/16/2025 | \$45.50 |
| Vision Plus Optometry | 12/20/2025 | \$225.00 |
| | | |
| | | |
| | | |
| | | |
| | | |

Total Amount Requested: \$

\$420.50

| | | | | | | |
|-------------------------------|-------------|------------------------------|-----------------------------|-------------|------------------------------|-----------------------------|
| Is this patient covered by a: | Dental Plan | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Vision Plan | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|-------------------------------|-------------|------------------------------|-----------------------------|-------------|------------------------------|-----------------------------|

Administrative fees charged for processing claims: X X

| Amount of Claim Eligible for Reimbursement | Administrative Charge as % of Claim |
|--|-------------------------------------|
| \$1- \$249 | 5.0% |
| \$250- \$499 | 4.5% |
| \$500- \$999 | 3.5% |
| \$1,000- \$1,999 | 2.5% |
| \$2,000 or more | 2.0% |

FAILURE TO SUBMIT REQUIRED DOCUMENTATION AND/OR SIGN EACH CLAIM FORM WILL CAUSE AN UNNECESSARY DELAY IN THE PROCESSING OF YOUR CLAIM.

Participant's Authorization:

By signing below, I hereby certify that (i) the expenses claimed have not been reimbursed, and are not reimbursable, under any other health plan coverage; (ii) the expenses claimed are medical expenses as defined by the Internal Revenue Service; (iii) effective 01/01/2017 - any dependent for whom I am seeking reimbursement is enrolled in an employer or union sponsored group health plan that provides minimum value; (iv) for any claim for reimbursement of health plan premiums, I paid for such premium on a post-tax basis (e.g., not through a pre-tax flex spending account); and (v) all the information I have provided in support of the above claim is complete, true and correct and all charges for which I am requesting reimbursement were actually paid by me or my dependent, where applicable.

Participant Signature _____ Date _____

WARNING: If any person makes a false or fraudulent statement in connection with a claim, including submitting false or fraudulent information or concealing a material fact, the Fund may take action to recover any amounts it paid (plus interest and costs) and take any other legal action as it deems appropriate. A false or fraudulent statement could also subject a person to taxes and penalties.

GUIDELINE FOR SUBMITTING MRP CLAIMS



All claims must be received within 12 months from the date of service. The 3/31 deadline NO longer applies. Also, you must be enrolled in MRP or RMRP both on the date of service and when claim is received.

There are multiple ways you can submit a claim for reimbursement:

TO SUBMIT YOUR CLAIM ONLINE

- ◆ GO TO: WWW.IATSENBF.ORG
- ◆ REGISTER AND/OR LOG IN TO YOUR ACCOUNT
- ◆ CLICK ON THE "MRP HISTORY/NEW CLAIM" BUTTON
- ◆ IT IS ADVISED THAT YOU SUBMIT A WRITTEN DETAILED LIST OF YOUR EXPENSES.
- ◆ SUBMIT ITEMIZED RECEIPTS
- ◆ SCAN THE LIST AND RELATED PROOF (RECEIPTS, EOB'S, DETAILED INVOICES) INTO ONE PDF FILE AND UPLOAD

TO SUBMIT YOUR CLAIM VIA US POST OFFICE OR VIA E-MAIL

- ◆ DOWNLOAD THE MOST CURRENT CLAIM FORM FROM THE FUND'S WEBSITE FROM THE 'APPLICATIONS/FORMS/DOCUMENTS' LINK – LOOK FOR *New Medical Reimbursement Claim Form (MRP)*
- ◆ COMPLETE FRONT, BACK AND SIGN THE MRP CLAIM FORM – ONE FOR EACH PATIENT
- ◆ SUBMIT COPIES OF DOCUMENTS (NO ORIGINALS) WHICH MUST BE ARRANGED IN ORDER BASED UPON THE LIST ON THE BACK OF THE CLAIM FORM OR YOUR PERSONALIZED LIST
- ◆ FOR ITEMS SMALLER THAN 8 1/2 X 11, SUBMIT A SEPARATE COPIED PAGE FOR EACH RECEIPT
- ◆ **MAIL TO: I.A.T.S.E. NATIONAL BENEFIT FUNDS, 417 FIFTH AVENUE, NY, NY 10016**
 - *IT IS ADVISED TO SEND VIA CERTIFIED MAIL/RETURN RECEIPT*
- ◆ **OR E-MAIL TO: CLAIMS@IATSENBF.ORG**

TO RE-SUBMIT YOUR PREVIOUSLY DENIED CLAIM

- ◆ DENIED DUE TO INCORRECT CLAIM FORM: DOWNLOAD MOST CURRENT CLAIM FROM THE FUND'S WEBSITE AND COMPLETE/SIGN – MUST ALSO SUBMIT THE ORIGINAL DENIAL EOB RECEIVED FROM THE FUND OFFICE
- ◆ DENIED DUE TO MISSING DOCUMENTS: SUCH AS YOUR INSURANCE COMPANY'S EOB (EXPLANATION OF BENEFITS), PLEASE OBTAIN THE MISSING DOCUMENTS AND RESUBMIT ALONG WITH THE FUND'S DENIAL EOB

**** IN ALL CASES, YOU MUST SUBMIT THE DENIAL EOB YOU RECEIVED FROM THE FUND OFFICE ****

It is advisable to submit claims on a regular basis to avoid delays in processing.

POST-TAX INSURANCE PREMIUMS

SUBMIT A COPY OF PAYSTUB(S) OR INVOICE

AND

PROOF OF PAYMENT: CANCELLED CHECK, BANK STATEMENT SHOWING PREMIUM DEDUCTIONS ALONG WITH AN EMPLOYER INVOICE/STATEMENT WHERE APPLICABLE

FOR MEDICAL/VISION/DENTAL EXPENSES

EOB'S FROM YOUR INSURANCE PROVIDER ARE REQUIRED

IF YOU HAVE NO VISION/DENTAL COVERAGE:
ON CLAIM FORM: CHECK EACH BOX ON PAGE 2
ONLINE SUBMISSION: INDICATE ON EACH VISION/DENTAL BILL THAT YOU DO NOT HAVE COVERAGE

FOR PRESCRIPTION EXPENSES

SUBMIT AN ITEMIZED PRINTOUT OR RECEIPT FROM YOUR PHARMACY WHICH MUST INCLUDE PATIENT NAME, DATE FILLED, DRUG NAME, RX NUMBER AND AMOUNT PAID