Office Use Only

Claim #: _____

Date Rvd:_____

Amount: _____

IATSE LOCAL 12 HEALTH AND WELFARE FUND

P.O. Box 362
Columbus, Ohio 43216-0362

Medical Reimbursement Claim Form

MEMBER'S INFORMATION:

Member's Name: First M.I. Last

Social Security Number: Date of Birth:

Address: Daytime Telephone No.

City: State Zip Code Evening Telephone No.

PATIENT'S INFORMATION: (You, Spouse, or Qualifying Children)

Patient's Name: First M.I. Last Date of Birth:

Relationship to Member:

Please Note: A separate claim form is required for each eligible Member, Spouse, or Dependent.

**IN ORDER TO QUALIFY FOR REIMBURSEMENT,
AN EXPENSE MUST MEET ALL OF THE FOLLOWING REQUIREMENTS**:

1) It must appear on the list of expenses that qualify for reimbursement on the back of this form.
2) It must be medically necessary.
3) It has not, or will not be reimbursed from another source.
4) It must be documented including the name, address, and telephone number of the provider.
5) A licensed provider as mandated by state law must perform it.
6) The date of service must be after 1/1/2003.

WHEN FILING A CLAIM:

1) Be sure you have completed, dated, and signed this form.
2) Attach copies of itemized bills, highlighting the amount that qualifies for reimbursement. The bill should show the name and address of the provider, the nature of the expense (i.e., whether the expense was for medical or dental services, prescription drugs, equipment, or other items), the date that the expense was incurred, the amount paid, and the date on which payment was made.
3) For insurance premiums, attach copies of the billing statement, and/or copies of pay stubs showing payment for medical insurance, highlighting the amount that qualifies for reimbursement.
4) Mail to address on top of the form.
5) Any questions regarding a claim must be submitted in writing to the health and welfare board at the above address.
6) Be sure to make copies of any information submitted, as it will not be returned.

MEMBER'S SIGNATURE:

I hereby certify that expenses claimed have not been reimbursed by any other health plan coverage. I hereby authorize any insurance company, prepayment organization, employer, hospital, or provider, to release all information with respect to myself or of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify that the information I have provided in support of this claim is complete, true, and correct and that all charges claimed was the amount paid.

_____ _____

Signed (Member) Date

Expenses that can qualify for reimbursement include:

(For a complete list qualifying expenses, please refer to IRS Publication 502)

- Abortion (Only legal abortions)
- Acupuncture *
- Alcoholism/Substance Abuse*
- Ambulance
- Ambulette
- Annual Physical Exam*
- Artificial Limb
- Artificial Teeth
- Birth Control Pills
- Chiropractors*
- Christian Science Practice
- Crutches
- Deductibles and Co-Insurance Payments
- Dental Treatment
- Diaper/ Diaper Service*
- Eyeglasses*
- Laboratory Fees
- Medical Care and Services
- Prescription Medicine
- Nursing Services*
- Operations*
- Oxygen
- Psychiatric Care*
- Sterilization
- Therapy
- Transplants
- Well Baby Care*
- Wheelchair*
- X-Rays

* May be subject to limits or specific rules, please refer to IRS Publication 502 for complete explanations. Publication 502 defines medical and dental care expenses. It contains an alphabetical list of items that you can or cannot deduct. It explains how to treat insurance reimbursements and other reimbursements you may receive for medical care. This publication is intended to explain what is tax deductible, but for the purpose of this plan any expense that is listed as deductible may be considered reimbursable.