**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. A separate form must be completed for each family member for whom you are requesting reimbursement. (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 Summary Plan Description booklet for the list of reimbursable items and further filing requirements beginning on page #25

**Participant Name:**
*Last* *First* *M.I.*

**Your Participant ID # or SSN:** Male ❒ Female ❒

**Your Date of Birth:**
*Month* *Day* *Year*

**Address:**
*Street* *City* *State* *Zip*

**Telephone #:** **E-Mail Address:**

**Name of other group health plan coverage:**

**Patient Name:**
*Last* *First* *M.I.*

**Patient's relationship to you:**

**Patient's Date of Birth:**
*Month* *Day* *Year*

**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.**

**List all items you are requesting reimbursement for:**

| Date of Service or Month of Coverage (for premium reimbursement) | Name of Provider or Name of Group Health Plan (for premium reimbursement) | Total Charges | Amount paid by Other Group Health Plan |
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**Total Amount Requested: $ _____**

**Administrative fees charged for processing claims:**

| 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**:
I hereby certify that (i) the expenses claimed have not been reimbursed, and are not reimbursable, under any other health plan coverage; (ii) 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 (iii) I hereby certify that the information I have provided in support of the above claim is complete, true and correct and that 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 paid by the Fund (plus interest and costs) and take any other legal action as it deems appropriate.***