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

Participant information:			
Last Name	First Name		
Participant ID# or SSN	Date of Birth (mm/dd/yyyy) ☐ check box if deceased		
Mailing Address Street	City	State	Zip
Email Address	Phone #		
Patient Information:			
Last Name	First Name	Date of Birth (mm/dd/yyyy)	
Is Patient Covered by a:	Dental Plan ❒ Yes ❒ No	Vision Plan ❒ Yes ❒ No	
Resubmission of claim	Indicate Original Claim # _____		

For the patient listed above, indicate all items you are requesting reimbursement for below. If needed, you can list additional expenses on a separate sheet of paper. **Paperwork should be in corresponding order**.

Proof attac-hed	**Full Name of Provider as indicated on your explanation of benefits (EOB)**	**Date of Service(s) or Period (for post-tax premiums) being claimed**	**Total Charges being claimed for reimbursement**
1. ❒			
2. ❒			
3. ❒			
4. ❒			
5. ❒			
6. ❒			
7. ❒			
8. ❒			
9. ❒			
10. ❒			
		Total Amount Requested: $	

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.

Claim Filing Instructions (please PRINT legibly):

- Please read, complete and SIGN this form. *Only the participant can sign this claim form. If claim is for a dependent, such dependent MUST be enrolled in a group health plan that provides minimum value. You must complete a separate claim form for each dependent.
- **Attach to this form, in order, based on list above**, all supporting documentation. See below:
  - For Medical Expenses: **copy of your other group health plan's explanation of benefits (EOB) which indicates**:
    - patient name,
    - provider name
    - date of service
    - type of service
    - amount paid by your insurance company
    - amount that is "your responsibility"

    EOB is required even if the expense is not covered through your insurance. Claim summaries are not acceptable unless it reflects the information above.
  - For prescription expenses**: itemized receipt, printout or mail order statement which indicates**:
    - patient name
    - pharmacy name
    - date filled
    - drug name
    - amount paid by you (your out of pocket cost)

    A cash register receipt is not acceptable unless it's for reimbursable items purchased over the counter. The receipt must reflect the name of the store. For over the counter items, please do not use a highlighter on receipt, just circle the requested items. Full name if item should be indicated on claim form if abbreviated on receipt.
  - For dental/vision expenses: **copy of your other group health plan's explanation of benefits (EOB).** If you do not have dental or vision coverage, indicate this on the reverse side and submit an itemized bill from your provider which reflects patient name, provider name/name of store, date of service, type of service and amount paid. For braces, submit copy of contract, detailed invoice and proof of payment.
  - For post-tax insurance premiums /Medicare/Medicare Supplemental/Long term care premiums submit:
    - Copy of your paystub which reflects the type of coverage (medical/dental/vision) OR
    - your health plan's premium statement/invoice AND
    - proof of payment (ex. front AND back of cancelled check, bank or credit card statement)
  - If claim was previously rejected by us: Submit copy of our denial EOB or indicate claim number from your original MRP claim along with requested information.

- Refer to the MRP Guidebook for Plan C-MRP and Plan R-MRP for a list of reimbursable items and the Summary Plan Description for further filing requirements beginning on page #26. This can be found on our website, www.iatsenbf.org. Note, there is an administrative fee, of up to 5% charged, for processing of claims.

How to submit this form: Only submit claim using one method below

- **Upload via website**: www.iatsenbf.org (preferred method)
- **Email to**: claims@iatsenbf.org
- **Mail to**: IATSE National Health & Welfare Fund
  Medical Reimbursement Claims Unit
  417 Fifth Avenue, Third Floor, New York, NY 10016-2204

  *If mailing, submit COPIES of your document on 8 ½ x 11 paper. Do not staple, use paperclip and put in order.

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

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 premium was paid, as applicable) and at the time the reimbursement is submitted to the Fund.