

# IATSE NATIONAL HEALTH AND WELFARE FUND

## PLAN C Medical Reimbursement Program Claim Form

Mail To: Administrative Services Only, Inc.  
Dept. 51  
PO Box 9005  
Lynbrook, NY 11563-9005

In New York.....1(516)396-5500

Outside New York.....1(800)537-1238

**FAXES NOT ACCEPTABLE**

MEMBER'S INFORMATION			
Member's Name: First		M.I.	Last
Social Security Number: 		Date of Birth:(month/day/year) _ / _ / _	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:		Apt. No.	Daytime Telephone No.
City	State	Zip Code	Evening Telephone No.

PATIENT'S INFORMATION			
Patient's Name: First		M.I.	Last
			Date of Birth:(month/day/year) _ / _ / _
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship To Member: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		
Name of all benefit plans covering this patient:			
Is this patient covered by a: (1) Dental Plan <input type="checkbox"/> Yes <input type="checkbox"/> No (2) Vision Plan <input type="checkbox"/> Yes <input type="checkbox"/> No			
I have submitted all Explanation of Benefit Vouchers covering the enclosed expenses: <input type="checkbox"/> Yes <input type="checkbox"/> No			

**ABOUT THE MEDICAL REIMBURSEMENT PROGRAM**  
This program assists with medical expenses that are not covered under your health insurance policy. As well, you may claim reimbursement of health insurance premiums you paid for a policy that includes you. Your Plan C quarterly statement lets you know how much of your CAPP account balance may be used for medical reimbursement.

**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.

MEMBER'S SIGNATURE	
I hereby certify that expenses claimed have not been reimbursed, and are not reimbursable under 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 any 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 billed.	
<u>REIMBURSEMENTS ARE PAYABLE TO MEMBERS ONLY</u>	
Signed (Member)	Date

**PLEASE READ REVERSE SIDE BEFORE SUBMITTING FORM**

## HOW TO FILE A CLAIM

- ① Be sure you have completed, dated and signed this form.
- ② After you have completed this form, attach copies of the itemized bills.
- ③ For insurance premiums, attach copies of the billing statement and proof of payment (i.e. a copy of cancelled check), and/or copies of pay stubs showing payment for medical insurance.
- ④ Attach copies of any Explanation of Benefits from any insurance company that has processed the bill.
- ⑤ Be sure to use a separate claim form for each eligible dependent.

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

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

- ① It must appear in the list of **EXPENSES THAT CAN QUALIFY FOR REIMBURSEMENT.**
- ② It must be medically necessary.
- ③ It has not, or will not be reimbursed from any other source.
- ④ It must be documented by a detailed statement including the name, address, telephone number and tax identification number of the provider.
- ⑤ It must be performed by a licensed provider as mandated by state law.
- ⑥ **ALL CLAIMS MUST BE RECEIVED BY MARCH 31ST OF THE FOLLOWING YEAR IN WHICH THEY OCCUR.**

## EXPENSES THAT CAN QUALIFY FOR REIMBURSEMENT

- ABORTIONS
- ACUPUNCTURE
- AMBULANCE
- ANNUAL PHYSICAL
- ARTIFICIAL LIMBS
- ARTIFICIAL TEETH
- BIRTH CONTROL PILLS
- CHIROPRACTORS
- CO-INSURANCE & DEDUCTIBLES
- CRUTCHES
- DENTAL TREATMENT
- EYEGASSES & EXAMS
- HEARING AIDS
- HOSPITAL SERVICES
- INSURANCE PREMIUMS
- LABORATORY FEES
- LEARNING DISABILITIES
- LONG-TERM CARE PREMIUMS
- MEDICAL SERVICES
- MEDICINES
- NURSING SERVICES
- OCCUPATIONAL THERAPY
- OPERATIONS
- OXYGEN
- PHYSICAL THERAPY
- PSYCHIATRIC CARE
- PSYCHOLOGISTS
- RECONSTRUCTIVE SURGERY
- STERILIZATION
- SUBSTANCE ABUSE TREATMENT
- TRANSPLANTS
- WHEELCHAIRS
- X-RAY FEES

**PLEASE REFER TO YOUR BENEFIT BOOKLET FOR A COMPLETE DESCRIPTION OF THE MEDICAL REIMBURSEMENT PROGRAM.**

## IF YOU HAVE ANY QUESTIONS REGARDING YOUR CLAIM

Please contact ASO regarding Medical Reimbursement Claims at:

In New York ..... | (516) 396-5500

Outside New York ..... | (800) 537-1238

*IATSE National Benefit Funds  
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New York, NY 10016*