## *N.E.C.A. LOCAL UNION NO. 313 I.B.E.W. HEALTH & WELFARE FUND*
## *MEDICAL REIMBURSEMENT ACCOUNT Request for Reimbursement*

☐ **NO** ☐ **YES (Claim Resubmission)**

| **EMPLOYEE INFORMATION (*Indicates Required Information)** | | | |
|---|---|---|---|
| LAST 4 OF SOCIAL SECURITY NUMBER* | LAST NAME* | FIRST NAME* | M.I.* |
| HOME ADDRESS* | | CITY* | ☐ Check if address is new |
| STATE* | ZIP CODE* | HOME PHONE* | WORK OR CELL PHONE |

**CLAIM FOR UNREIMBURSED HEALTH EXPENSES (ATTACH SUPPORTING DOCUMENTATION)**

| DATE EXPENSE INCURRED | NAME OF SERVICE PROVIDER | EXPENSE DESCRIPTION | PERSON FOR WHOM EXPENSE INCURRED | $ AMOUNT OF REIMBURSEMENT REQUESTED |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**EMPLOYEE SIGNATURE REQUIRED - READ CAREFULLY**

The undersigned participant in the Medical Reimbursement Account (MRA) certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the MRA with respect to such expenses. The undersigned fully understands that he/she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim. The undersigned also acknowledges that the reimbursements hereby requested have not been and are not reimbursable under any other coverage. I have read and understand the important information on the reverse side of this form. I understand that any amounts reimbursed may not be claimed on my or my spouse's tax returns.

| EMPLOYEE SIGNATURE *(Required)* | DATE |
|---|---|
| | |

**Remember:** Claim must be submitted with itemized receipts and EOBs. Please send completed form along with all required documentation to:

N.E.C.A. Local Union No. 313 I.B.E.W Health & Welfare Fund
3 Gateway Center, 401 Liberty Avenue, Suite 1200
Pittsburgh, PA 15222-1024

**IMPORTANT INFORMATION REGARDING REIMBURSEMENTS**

Please fill out the form completely using a separate line for each individual covered expense. Do not lump expenses together. Sign and date the bottom of the form and keep a copy of the completed form and all attached documentation for your records. An incomplete form or missing documentation may result in a delay or denial of reimbursement. **All information must be complete prior to the reimbursement filing deadline in order to be considered.**

**PARTIAL REIMBURSEMENT:** In the event that a claim is only partially reimbursed, unpaid balances from the partially reimbursed claims will not be eligible for future reimbursement.

**TYPE OF SUPPORTING DOCUMENTATION**

- **EOB**s - For expenses covered by the N.E.C.A. Local Union No. 313 I.B.E.W. Health & Welfare Fund or other health care plan you must submit those expenses under the health care plan first. A copy of the Explanation of Benefits (EOB) Statement which explains the amounts paid and not paid by the health care plan must be attached to this form. For copies of EOBs from Aetna for the Health and Welfare Fund you can contact Zenith American Solutions at 1-302-761-1080. If the expenses are covered through secondary coverage by another health care plan, you must attach EOBs from all health care plans.

- **Itemized Statements or Receipts** - Expenses for services covered by the Health and Welfare Fund for other health coverage (such as hearing aids, Lasik vision surgery and other vision expenses) you must provide an itemized statement or receipt from the provider which contains all of the following:

  - Name of person receiving the service
  - Nature of service or supplies
  - Name and address of service provider
  - Amount charged
  - Indication that payment was made
  - Date service was rendered

**Note:** Balance forward statements, cancelled checks or credit card receipts are not acceptable as documentation of a covered expense. However, cancelled checks and credit card receipts can be submitted along with an itemized statement to show proof of payment.

**COVERED EXPENSES INCLUDE:**

- Expenses for services or supplies which are covered under the Health and Welfare Fund, but are the financial liability of the participant as a result of the application of deductibles, coinsurance or maximum benefit limitations.

**NON-COVERED EXPENSES INCLUDE:**

- Office Visit Co-Pays.

**IMPORTANT LIMITATIONS ON COVERED EXPENSES**:

- As required by Federal law, to be eligible for reimbursement under this benefit, all expenses must not have been reimbursed or be eligible for reimbursement under any other health plan coverage or a Flexible Spending Account; and
- The Covered Expense must have been incurred while the person receiving the service or supply was eligible for benefits under the N.E.C.A. Local Union No. 313 I.B.E.W. Health & Welfare Fund; and
- Proper documentation of the expense and payment must be provided.
- Your Medical Reimbursement Claims must be submitted within one year (12 months) of the date the service was rendered.