Mail this form to: IATSE National Health & Welfare Fund
Medical Reimbursement Claims Unit
417 Fifth Avenue, Third Floor
New York, New York 10016

E-mail this form to: claims@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. For reimbursement of a dependent's expenses: Such dependent MUST be enrolled in a group health plan that provides minimum value. You must complete a separate reimbursement form for each dependent. (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 MRP Guidebook for the list of reimbursable items and the Summary Plan Description for further filing requirements beginning on page #26

* **If you are submitting a claim for expenses that are not shown on your explanation of benefits, a detailed invoice is required. The Claims Department will determine if these expenses are reimbursable.**

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

Your Participant ID # or SSN:

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

Permanent Mailing Address:
Street *City* *State* *Zip*

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

Name of other group health plan coverage:

ONLY ONE PATIENT PER CLAIM FORM

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.

**Please complete the reverse side of this page

List all items you are requesting reimbursement for the 'patient' listed on page 1 of this claim form.
Each patient requires a separate claim form be completed:

Name of Provider of Service	Dates of Service(s) / Period being claimed	Total Charges being claimed for reimbursement

Total Amount Requested: $ _____

Is this patient covered by a:

Dental Plan Yes ☐ No ☐ **Vision Plan** Yes ☐ No ☐

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 OR MAY CAUSE YOUR CLAIM TO BE REJECTED.

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.*

GUIDELINE FOR SUBMITTING MRP CLAIMS

All claims must be **received** within 12 months from the date of service. You must be enrolled in MRP/RMRP both on the date of service and when claim is received.

submit a claim for reimbursement:
It is advisable to submit claims on a regular basis to avoid delays in processing.

Upload claim on our website, www.iatsenbf.org

- Log into your account. On your dashboard, select "MRP History/New Claim" button
- Complete MRP claim form or submit itemized list of expenses along with total amount you are requesting.
- Scan MRP Claim form or itemized list and proof (EOB's, receipts, itemized bills, invoices etc) into ***one*** **PDF** and upload.
- A separate submission is required for each patient.

Mail claim to the Fund Office (advised to send via certified mail/return receipt) or email to claims@iatsenbf.org

- Read, complete (front & back) and sign new MRP claim form for EACH patient.
- Submit COPIES of documents arranged in order based on the list on the back of the claim form. We can accept originals, however, we may not be able to return the originals upon request since they are scanned into our system and then the submission is destroyed, so please always submit copies only. **Itemized list is requested**. See below chart for required documents.
- For all items smaller than 8 ½ by 11, make enlarged copy. Multiple receipts can be on one piece of paper, however, it must be in date order.
- Do NOT staple claim, use paperclips and avoid folding claim, if possible.
- Mail to: IATSE National Benefit Funds, 417 Fifth Avenue, 3rd floor, New York, NY 10016

Resubmitting a denied claim:

- If denied due to incorrect claim form/not signed: Submit a completed/signed new MRP claim form.
- If denied due to missing documents: resubmit with required proof.
- Submit a copy of OUR denial EOB in ALL cases when resubmitting claims for re-processing
- Claim submitted for re-processing must be received within 45 days from the date on our Explanation of Benefits (EOB) or within 12 months from the date of service, whichever is later.

Documentation needed along with claim:

For Post-Tax Insurance Premiums:
Copy of paystubs OR
Copy of invoice AND proof of payment (ex. copy of cancelled check or bank statement)

Prescription Expenses
Itemized printout or receipt from pharmacy which must indicate the following:

Patient name
date filled
drug name
amount paid

For Medical/Dental/Vision Expenses: Explanation of Benefits (EOB) from YOUR primary carrier reflecting the following:

- Patient name
- Date of service
- type of service
- provider name
- amount charged
- amount paid (if any) by your insurance

Proof of payment for the charges you are responsible for is NOT required.

For dental/vision expenses, indicate on page 2 of claim form if you have insurance. If you do not, submit itemized bill.

For braces, submit copy of contract, detailed invoice and proof of payment within 12 months from date of service