Ironworkers Intermountain Health and Welfare Trust Fund

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HEALTHCARE REIMBURSEMENT ACCOUNT REIMBURSEMENT REQUEST FORM

1. Type or print information (items 1 through 6) on the Employee Section below. Only one patient can be listed on a request form. However, **more than one provider can be listed for that one patient**.

2. Enter the total amount for which the claim is being made in the appropriate sections.

3. Supporting documentation must accompany this request form. Supporting documentation may include the following:

   - Explanation of Benefit statement(s).
   - Itemized bills or invoices from your health care provider or medical supplier.
   - A copy of your prescription.
   - Cash register receipts. (Cash register receipts, alone, are not sufficient documentation.)

   Supporting documentation must describe the service or product, the amount of the expense, the date of the service or sale, and identify the person for whom the expense was incurred.

   For dual-purpose items (that is, items that could be for personal as well as medical reasons, such as massage therapy), you must include documentation showing that the expense was incurred for medical reasons. Generally, you must include your provider's diagnosis of a medical condition and recommendation of the item to treat that condition.

4. Retain copies of supporting documentation for your records.

5. Send the completed claim form and supporting documentation to the Administrative Office at the address above (attention HRA Claims), or via the email address or fax number above.

NOTE: ANY ITEMS FOR WHICH YOU ARE REIMBUSED CANNOT BE CLAIMED AS DEDUCTIONS OR CREDITS ON YOUR FEDERAL INCOME TAX RETURN.

1. Employee's Name	2.Social Security Number	3.Address
4.Patient's Name	5.Relationship	
6.ProviderName(s)		

UNREIMBURSED HEALTH CARE EXPENSES

Type of Expense	Date of Service	Claim Amount to be Reimbursed
Deductible	_____	$ _____
Coinsurance/Co-Payments	_____	_____
Not covered by Plan	_____	_____
Other: _____	_____	_____
		Total $_____

I certify that the above expenses were incurred for me or my eligible dependent(s), and that these expenses are medical care expenses under Tax Code Section 213(d). I certify that these expenses have not been reimbursed and I will not seek reimbursement for them under a major medical plan or any other health plan, such as an individual policy or my dependent's health plan. I understand that the expense for which I am reimbursed may not be used to claim any federal income tax deduction or credit. I understand no assignment will be accepted and all reimbursements will be made to me.

_____

Employee Signature Date