

# MEDICAL REIMBURSEMENT ACCOUNT

HEALTH CARE REIMBURSEMENT REQUEST FORM

BOILERMAKERS LODGE NO. 154

**Completed form to be returned to:**

GEM Group  
1200 NUMBER THREE GATEWAY CENTER  
PITTSBURGH, PA. 15222

**TELEPHONE NUMBER:**

(412) 471-2885

**INSTRUCTIONS**

1. Type or print all information in the Employee Section below. Please Complete a separate Reimbursement Request Form for each provider for which you are filing a claim.
2. Complete the Health Care Expenses section with the date of service. List the reimbursement amount next to the type of reimbursement being requested (deductible, coinsurance, etc) and then enter the total claim amount.
3. Attach supporting documentation to the request form. This documentation should include the following:
  - \*Explanation of Benefits indicating deductibles, co-insurance, and amounts in excess of reasonable and customary for you or your eligible dependents.
  - \*Itemized bills from your doctor, dentist, or other provider for expenses not covered by your Medical, Dental, or Vision plan.
  - \*Itemized statements for Qualified Dependent Care Expenses or Medicare Part B Premiums.
  - \*Itemized bill for Boilermaker's continuation coverage under the COBRA or self-payment provisions.
4. Send completed claim form to the address listed at the top of this form.

**Employee Section**

Name		Social Security Number	
Address			
City	State	ZIP CODE	
Name of Patient		Relationship	
Provider Name		Service Type	

**Health Care Expenses** (Expenses not covered or not paid by your plan or any other plan)

Date(s) of Service	<b>FROM:</b> _____	<b>TO:</b> _____
Claim Reimbursement Amounts:		
Deductible		<b>Claim Office Use Only</b> Request Number _____ Date _____ Amount _____
Co-Insurance		
Excess Reasonable & Customary	\$ _____	
Not Covered by the Plan	\$ _____	
Health Coverage COBRA/Self Payment	\$ _____	
Medicare Part B Premium	\$ _____	
Qualified Dependent Care	\$ _____	
<b>REIMBURSEMENT TOTAL</b>	_____	

Do you wish payment to be made directly to the provider of service?  yes  no

I certify that either I and/or my eligible dependent(s) have incurred the expense for which reimbursement is claimed from the the Medical Reimbursement Account.

\_\_\_\_\_  
(Member Signature)

\_\_\_\_\_  
(Date)