IBEW - LOCAL NO. 704 IBEW WELFARE FUND
HEALTH REIMBURSEMENT ACCOUNT PROGRAM
MEDICAL REIMBURSEMENT REQUEST FORM

CONSOCIATE HEALTH

Participant Information

Name: _____ Social Security Number: _____

Address: _____

Instructions: Complete the table on the reverse side of this form for eligible expenses incurred by you and/or your Dependents. Requests must be received by Consociate Health no later than one year (12 months) following the date on which the expense was incurred. Sign and date this form, then send it, along with your supporting documentation, to Consociate Health at 2828 N. Monroe St, Decatur, IL 62526 Attn: HRA Claims Dept.. Claims may also be submitted via fax (217.233.2281), email (flex@consociate.com) or via the online portal (www.consociatehra.com) or mobile app. If the participant is entitled to reimbursement under the rules and provisions of this Plan, the reimbursement will be issued via direct deposit. Members should expect the direct deposits to be deposited within 7-10 business days following receipt of the claim. If you have any questions, please contact our Customer Service Department at 888.242.4357, Monday through Friday 8am-5pm CST.

INFORMATION THAT MUST BE PROVIDED BEFORE HRA REIMBURSEMENT WILL BE ISSUED

1. Completed Reimbursement Request Form.
2. Completed ACH form for Direct Deposit along with banking information, if not previously submitted or if you are updating your information.
3. All explanations of benefits (EOBs) from any health plans involved in paying medical expenses.
4. For those allowed claims that no EOB is generated (such as prescriptions and vision claims), documentation showing proof of payment or other evidence that qualified medical expenses incurred. For example, when you pick up a prescription, you receive a leaflet showing name of patient and dollar amount paid that is attached to the bag. This must be submitted or ask for a print out from your pharmacist. The documentation must include all required identifiers such as patient's name, date of service, description of item purchased, and dollar amount of purchase. Documentation does not include cash register receipts because they normally do not contain the required identifiers. No taxes or late fees are allowed to be reimbursed.
5. **If appropriate documentation is not submitted the claim will be denied and you will not receive reimbursement until the appropriate documentation is submitted.**
6. **PLEASE USE THE REVERSE SIDE OF THIS FORM FOR MEDICAL REIMBURSEMENT REQUESTS.**

To the best of my knowledge and belief, my statements on this Form are complete and true. I certify all of the following: either my Dependent or I have received the services described on the reverse side of this form on the dates indicated and the expenses are my out-of-pocket expenses that qualify as valid qualified medical expenses under the Plan. I have not been reimbursed previously for these expenses under the Health Reimbursement Account Program. These expenses have not been reimbursed or are not reimbursable under any other source available for reimbursement (e.g. the Fund's health plan or any other health plan, such as my Spouse's plan). I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit. I authorize a deduction in my Health Reimbursement Account in the amount of the reimbursement.

PARTICIPANT'S SIGNATURE:_____ **DATE:** _____

DATE OF SERVICE	PRINT PATIENT'S NAME	PATIENT'S RELATIONSHIP TO PARTICIPANT (Example Spouse, Son, Daughter)	PRINT PROVIDER'S NAME	TYPE OF SERVICE (Medical, Dental, Rx or Vision)	AMOUNT	FOR OFFICE USE ONLY
TOTAL						