Boilermakers Lodge No. 154 Welfare Fund
Administered by Wilson-McShane Corporation
3001 Metro Drive - Suite 500
Bloomington, MN 55425
Phone: (412) 800-7010

MEDICAL REIMBURSEMENT ACCOUNT
HEALTH CARE REIMBURSEMENT REQUEST FORM

INSTRUCTIONS:

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.

1. Complete the Health Care Expenses section with the date of service. List the reimbursement amount next to the type of reimbursement being requested (deductible, co-insurance, etc.) and then enter the total claim amount.
2. 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 Medical Part B Premiums.
   - Itemized bill for Boilermaker's continuation coverage under the COBRA or self-payment provisions.
3. Send completed claim form to the address listed at the top of this form.

PARTICIPANT SECTION:

Name: _____ Social Security Number: _____

Address: _____ State: _____ Zip Code: _____

Name of Patient: _____ Relationship: _____

Provider: _____ Service type: _____

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

Date (s) of Service From: _____/_____/_____ To: _____/_____/_____

Claim Reimbursement Amounts:

Deductible	$_____
Co-insurance	$_____
Excess Reasonable & Customary	$_____
Not covered by the Plan	$_____
Health Coverage COBRA/Self Pay	$_____
Medicare Plan B Premium	$_____
Qualified Dependent Care	$_____
REIMBURSEMENT TOTAL:	$_____

For office use only
Request Number:
Date: _____
Amount: _____

I certify that I am enrolled in major medical coverage in a group health plan that meets the minimum value standard under the Patient Protection and Affordable Care Act and that either I and/or my eligible dependent(s) have incurred the expense for which reimbursement is claimed from the Medical Reimbursement Account.

Participant's Signature: _____ Date: _____