

**RETURN COMPLETED FORM TO:**  
 150 1<sup>st</sup> Avenue, Suite 450  
 Cedar Rapids, IA 52401  
 1-319-365-2810



**HEALTHCARE REIMBURSEMENT ACCOUNT PAYMENT REQUEST FORM**

Member Name \_\_\_\_\_ Date \_\_\_\_\_

Members SSN \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Members Address \_\_\_\_\_

Is this a change of address? YES  NO

REQUEST FOR MISC EXPENSES		OFFICE USE ONLY _____	
MEDICAL EXPENSES	\$ _____	CODE _____	CODE _____
DENTAL EXPENSES	\$ _____	DOS _____	DOS _____
VISION EXPENSES	\$ _____	AMT _____	AMT _____
OTHER EXPENSES	\$ _____	_____ HR	_____ HR
TOTAL	\$ _____	DOS _____	DOS _____
		AMT _____	AMT _____
		_____ HR	_____ HR

YOU MUST ENCLOSE A COPY OF THE ITEMIZED BILL OR EXPLANATION OF BENEFITS (EOB) FORM FROM THE PPO FOR MEDICAL EXPENSES. **(INSTRUCTIONS AND COVERED EXPENSES ARE LISTED ON THE REVERSE SIDE.)**

**By signing this request form, you certify that you have not taken and will not take a tax deduction for items submitted for reimbursement and that there is no other source available for payment. You also certify that you have not submitted these expenses on a prior request form.**

SIGNATURE \_\_\_\_\_

PLEASE SUBMIT THE ORIGINAL FORM TO THE FUND OFFICE.  
 THE OTHER COPY MAY BE MAINTAINED FOR YOUR RECORDS.

**IMPORTANT REMINDER**

Your Healthcare Reimbursement Account is not a savings account and you are not vested in the balance. Amounts in the account can be used only for the expenses shown on the reverse side of this form. The Board of Trustees can change the list of covered expenses and any of the Healthcare Reimbursement Account's rules and procedures at any time.

## **COVERED EXPENSES THAT CAN BE REIMBURSED FROM YOUR HRA**

(Only expenses incurred after the employee's participation date are eligible to be reimbursed.)

- Deductibles and co-payments from the regular benefit plan
- Wellness exams & immunizations
- Lasik surgery
- Medical/dental/vision expenses in excess of regular plan maximums
- Hearing aids
- Birth control pills
- Retiree self-payments for Welfare Fund coverage
- Fertility enhancement
- Psychiatric care
- Smoking cessation programs
- Medically supervised weight loss programs (but not food/supplements)
- Acupuncture
- Special telephone and television equipment for hearing impaired persons
- Guide dogs for blind or deaf persons
- Subject to special IRS rules:
  - Certain costs of modifying the home or car of a disabled person
  - Certain lodging expenses while accompanying a patient
  - Certain transportation expenses for medical treatment
  - Qualified special schooling expenses for mentally impaired or physically disabled

## **NON-COVERED EXPENSES**

- Over-the-counter drugs
- Cosmetic surgery and treatments
- Household help
- Charges incurred by a person not covered by the Plan
- Health club memberships/expenses
- Child and dependent/elder care expenses
- Burial expenses
- Sales tax, shipping & handling fees
- Long-term care insurance premiums
- Expenses reimbursed by some other source
- College tuition/books
- Environmental devices such as, air conditioners, air purifiers, or humidifiers

**In addition, previously paid self-payments that were paid in cash or by check or money order cannot be reimbursed at a later date from the Healthcare Reimbursement Account.**

## **INSTRUCTIONS**

- For all other types of claims you must enclose an itemized copy of the bill stating the provider's name and address, patient name, and date of service or a copy of the Explanation of Benefits from the PPO. **Collection notices and bills indicating only a balance due are not acceptable. (Cash register receipts from providers are also NOT acceptable.)**
- The minimum amount requested should be \$50 unless you have accumulated less than \$50 in a year.
- You have *one year* from the date of service to submit a request for reimbursement.