

**CENTRAL PENNSYLVANIA TEAMSTERS  
HEALTH AND WELFARE FUND**

**HEALTH REIMBURSEMENT FORM**

Please attach copies of your receipts and send to the Fund Office. You must provide proof that the services have been paid. Although you must supply receipts, you do not have to list each prescription separately below, please indicate patient name, date of service, and the total amount.

**REMINDER:** Participants shall submit all applications for reimbursement no later than one year after the date of service or the date the expense claim was incurred. The maximum reimbursement that a Participant can receive is equal to their account balance at the time the reimbursement was requested.

Participant Name \_\_\_\_\_ Participant ID #CPT \_\_\_\_\_

<u>Patient Name</u>	<u>Date of Service</u>	<u>Amount</u>
_____	_____	_____
_____	_____	_____
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_____	_____	_____

(OVER)

In order to receive reimbursement, the Participant must submit documentation for each item or service and the documentation must demonstrate that the Participant (or patient) actually paid the amount for which reimbursement is being sought. Examples of this documentation include, but are not limited to the following:

- For office visits, inpatient or outpatient facility copays —a health plan's Explanation of Benefits (EOB) statement or an itemized receipt or bill from the provider that includes the patient's name, a description of the service, and the original date of service and the patient's portion of the charge.
- For prescription drugs — A pharmacy statement or receipt from the pharmacy including the patient's name, the Rx number, the name of the drug, the date the prescription was filled, and the amount.
- For over-the-counter medicines — A written or electronic OTC prescription along with an itemized cash register receipt that includes the merchant name, name of the OTC medicine or drug, purchase date, and amount, OR a printed pharmacy statement or receipt from a pharmacy that includes the patient's name, the Rx number, the date the prescription was filled, and the amount.
- For over-the-counter health care-related products — An itemized cash register receipt with the merchant name, name of the item/product, date, and amount. These include items like crutches, supplies such as bandages, and diagnostic devices such as blood sugar test kits.

Reimbursement shall be made to Participants within the Fund's regular claims processing protocol. Participants must submit all applications for reimbursement no later than one year after the date of service or the date the expense claim was incurred.

The maximum reimbursement amount that a Participant can receive is equal to his or her account balance at the time the reimbursement request is processed.

Any monies that are not expended in one plan year will be rolled over to the next plan year and will continue to be available to the individual for reimbursement of qualified medical expenses.

A Participant who is eligible to elect COBRA but fails to do so, or who elects COBRA coverage but ceases COBRA coverage, will only be eligible to receive reimbursement for claims that are incurred while the individual was a Participant on account of his active employment or because they elected COBRA coverage (provided that the request for reimbursement is timely made and includes all required documentation).

At no time will any Participant or any other person be eligible to receive cash payment from the Fund under this HRA without documentation of qualified medical expenses.

**IF NO PROOF OF PAYMENT IS SUBMITTED WITH YOUR DOCUMENTATION, YOU WILL NOT BE ELIGIBLE FOR REIMBURSEMENT FOR THAT SERVICE.**