Ironworkers Intermountain Health & Welfare Trust Fund

Vision Member Reimbursement Claim Form

PO Box 240127
Apple Valley, MN 55124
Phone: (801)904-4897 or (888)867-9510
Submit reimbursement requests via Fax: (801)386-7396
Or email: staff@iiwbenefits.org

Information Required for Processing:

- ✓ Itemized bill reflecting proof of payment
- ✓ Provider's name, address, phone number & Tax ID
- ✓ Procedure Code (CPT) and Diagnosis Code (ICD)
- ✓ Cash register receipts alone are not acceptable

Member's Name: _____

Member's DOB: _____ Alt ID or Last 4 SSN: _____

Address: _____

Phone Number: (Home) _____ (Work) _____ (Cell) _____

Patient Name: _____ Patient's DOB: _____

Provider's Name: _____ Tax Id: _____

Provider's Address: _____

Provider's Phone #: _____

CPT: _____ _____ _____ _____
ICD: _____ _____ _____ _____

Date of Service	Provider	Billed Amount

Member's Signature: _____ Date: _____