

# I.U.P.A.T. Welfare Fund

P.O. BOX 99459

TROY, MICHIGAN 48099-9998

TEL: (330) 779-8865 Tol Free (833) 697-1294

Fax: (248) 556-2597 Email: flexclaims@benesys.com

## Health Care Reimbursement (HCA) Claim Form

**Instructions:** To receive benefits from your HCA account, you must complete **ONE FORM per patient**, along with the following information:

**Reimbursement for:**

Medical Co-payments

Dental and Vision Services

Prescription Payment or Co-Payment

**Information Required:**

Copy of your Explanation of Benefits Form (EOB).

**Balance due statements are not acceptable.**

A copy of a detailed invoice listing the services rendered and the charge for each.

**Orthodontic services will be paid for after services are rendered.**

A copy of the drug label stub or a printout from your pharmacy.

**Cash register receipts are not acceptable.**

**PLEASE NOTE:**

- The deadline to submit reimbursement requests for unreimbursed medical expenses is 12 months from the date the expense was incurred.

You MUST allow up to 30 business days for reimbursement.

Member's Name: \_\_\_\_\_ Member's SS# \_\_\_\_\_  
or Alternate ID: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Patient Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Type of Service <small>(Medical, Dental, Vision, Prescription)</small>	Provider Name	Date of Service	Amount of Claim
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____

I hereby authorize payment for the above services for which I am requesting benefits:

By signing this form, I understand that benefits shall be paid in accordance with the I.U.P.A.T. Welfare Fund requirements and limitations established by the Board of Trustees. (See the reverse side of this form for a brief description of covered benefits).

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(OVER)

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### **Health Care Reimbursement (HCA) Claim Form**

#### **What is a H.C.A.?**

A Health Care Reimbursement Account (HCA) is established for each Active Participant. A HCA is an account to be used by the Participant for reimbursement of out-of-pocket health care costs incurred by the Participant or his/her Dependents.

#### **Eligible Expenses:**

The Plan will periodically provide a list of the types of medical expenses that may be reimbursed under the Plan. Medical expenses incurred by the participant under the Plan are eligible for reimbursement from a Participant's HCA if they:

- Qualify as a medical expense under §213 of the Internal Revenue Code; and
- Have not been or will not be otherwise paid by the Plan or have not been reimbursed by or are not reimbursable under any other health plan coverage.

#### **Please submit all requests to:**

**I.U.P.A.T. Welfare Fund**

**P.O. BOX 99459**

**Troy, MI 48099-9998**

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#### **What expenses are not allowed?**

Benefits payable under the HCA are subject to IRS rules and regulations regarding the IRS definition of medical expenses, which may be included in medical expense deductions.

The following is a brief list of expenses not payable under the HCA.

They include but are not limited to:

- ◆ Vitamins/ Supplements (whether prescribed by a doctor or not)
- ◆ Over the counter drugs or supplies
- ◆ Acne Treatments ◆ Cosmetics ◆ Chapstick ◆ Dietary Supplements ◆ Face Cream ◆ Fiber Supplements ◆ Medicated Shampoo/Soaps ◆ Moisturizers ◆ One-A-Day Vitamins ◆ Suntan Lotion ◆ Toiletries ◆ Toothbrush ◆ Toothpaste ◆ Topical Creams
- ◆ Eyeglass Protection Plans are not eligible.