UNITED STEELWORKERS

USW HRA FUND

REIMBURSEMENT CLAIM SHORT-FORM

If Faxing total # of Pages: _____

RECEIVED IN OFFICE

FOR FUND OFFICE USE ONLY
Claim Number: _____
Processor: _____
Total Claim: _____
Approved Amount: _____ Code: _____
Denied Amount: _____ Code: _____

PARTICIPANT INFORMATION (Please print)

Name: _____

Address: _____

City, State, Zip: _____

Last 4 digits of SSN: xxx-xx-_____

Email: _____

Day Phone: _____

INSURANCE INFORMATION (Check all that apply)

- Were any of these medical expenses excluded from your health insurance coverage? ☐ Yes ☐ No
- Were any of these medical expenses covered by secondary health insurance coverage? ☐ Yes ☐ No
- Were any of these claims covered by dental or vision insurance? ☐ Yes ☐ No

UNREIMBURSED MEDICAL EXPENSES (Attach supporting documentation)

Does your receipt include all of the following?

❑ Provider's name ❑ Provider's address

❑ Services provided ❑ Amount billed

❑ Actual date(s) of service: Date of payment is not sufficient

Person for Whom Expense was Incurred	Date(s) of Service	Name of Service Provider	Description of Services	Total Expense(s)	Fund Use Only

PARTICIPANT CERTIFICATION – *PLEASE READ CAREFULLY*

The above is a true and accurate statement of all eligible medical expenses incurred by my eligible dependents or me on the date(s) indicated. I attest that I and my eligible dependents, as applicable, are enrolled in other group health plan coverage that provides minimum value as defined under the Affordable Care Act. Supporting documentation from my service provider(s) for all expenses is attached to this claim form. I understand that I cannot claim any reimbursed medical expenses on my income tax return and that I may be liable for payment of all related taxes, including Federal, State or City income tax, on the amounts paid for any expense improperly claimed under the provisions of the USW HRA Fund. I acknowledge that I have read and understand the additional participant certification included in the *Important Claims Submission Information Page*, which is incorporated herein by reference, and I agree to such certifications contained therein.

_____ _____

Participant Signature ***Date***

Mail To: USW HRA Fund
1101 Kermit Dr, Suite 800
Nashville, TN 37217

Fax To: (615) 333-5797
Email To: hra@uswbenefitfunds.com
Phone: (855) 450-1875; (855) 723-0210

Access your account information 24 hours a day, seven days a week on our website: www.uswbenefitfunds.com

USW HRA Fund
Important Claims Submission Information
Please DO NOT Fax or Mail This Page

Definition of "Incurred"

The term "incurred" used throughout this form refers to the date you or your eligible dependent is provided the care that gives rise to the medical, dental, vision, prescription, or other qualifying expense. This date could be different than the date you are billed or pay for the expense.

Additional Participant Certification

I certify the expenses for which I am claiming:

- **Were incurred by me or my eligible dependents (spouse is considered a dependent) during a plan year in which I and/or my dependent(s) were covered under this Plan.**
- **If over-the-counter medication or drugs, were incurred solely to alleviate or treat personal injury or sickness.**
- **Will not be claimed as a deduction or credit on any personal income tax return.**
- **Are eligible according to the terms of the Plan. If I've received a reimbursement for expenses later found ineligible, I must return the reimbursement to the Fund, or I will be responsible for taxes or penalties arising from the ineligible expenses.**
- **I understand that USW HRA Fund may scan my claim and expense documentation and store them as digital images. My original claim and expense documentation may be destroyed by USW HRA Fund within a reasonable time period after receipt.**
- **If I am also a participant in a Section 125 Health Care Flexible Spending Account Plan ("FSA"), I certify that I have exhausted all my benefits under the FSA prior to filing this claim.**
- **I certify I was not reimbursed and this claim is not reimbursable under any other medical plan that provides the Participant or Dependent with health coverage.**

Faxing and Mailing Tips

To receive the fastest possible reimbursement, email your claim online to hra@uswbenefitfunds.com. If you do not have internet access you can submit your claim by using our fax line. You can also mail your claim; however, you may experience slower reimbursements due to mailing delays. Faxed or mailed claims require up to seven **business days for review.**

Please do not use a highlighter on this form or claim documentation. Instead, circle and add notations with a dark pen.

Fax and Scanning Tips

- **Complete claim form using a dark pen (do not use pencil).**
- **If your documentation is printed on dark paper, copy it onto lighter paper.**

Mailing Tips

- **Do not mail originals.**
- **Do not staple**
- **Neatly tape any small receipts onto a 8½ by 11" piece of paper**

Fax or mailed claims may not be verified until up to seven business days after receipt.

Helpful Hints on How to Successfully File a Claim

- **Documentation must clearly list the date the service was incurred, provider name, type of service, patient name, and your portion of the service provided.**
- **If the expense incurred is reimbursable by an insurance company, you must submit the expense to the insurance company FIRST. You can then use the Explanation of Benefits (EOB) received from the insurance company as your expense documentation. The EOB you receive from your insurance company is the best source of expense documentation for use in submitting your claims.**
- **Canceled checks, 'balance forward' statements, 'previous balance' statements, 'paid on account' statements or receipts, charge card receipts, or charge card statements are not acceptable forms of expense documentation according to the IRS as they do not clearly indicate the date or type of service.**
- **For prescription expenses, submit the prescription receipt you received with the medication purchased showing the patient name, medication name, the date the prescription was filled, and the amount you owe for the medication. Cash register receipts or charge slips for prescription purchases cannot be accepted as they do not indicate the medication name or patient.**
- **For over-the counter medications for which you have a subscription, submit an original cash register receipt that clearly indicates the item name (such as cold medicine, antacid, allergy medicine, or pain reliever), date, and cost of the item purchased. According to the IRS, handwriting the required information on the receipt or attaching box tops or other product information to the receipt is NOT acceptable. Insufficiently documented claims are not eligible for reimbursement.**
- **All expenses must be incurred prior to being considered for reimbursement. If the expense has not been incurred, it is not eligible for reimbursement.**
- **Keep copies of your claim. You can submit *legible* photocopies of your expense documentation.**

Definitions

Dates of Service – **The date the service was incurred. This date could be different than the date you are billed or the date you pay for the expense. Prescription drugs are based on the date the prescription is filled and eyeglass/contact lens purchases are based on the date ordered. These dates could be different than the date picked up or the date paid.**

Provider Name / Type of Service – **Doctor name, store name, dentist, clinic, hospital, etc. along with what service was performed (for example, 'Dr. Smith/Office visit', ABC Drug Store / Prescriptions,' or 'The Vision Store / Contacts').**