IBEW 292 Benefits Office
6700 W. Broadway Ave, Ste B
Brooklyn Park, MN 55428
(763) 493-8830 | (800) 368-9045 | ibew292benefits.org

I.B.E.W. 292 Health Care Plan

Medical Reimbursement Request

It is the responsibility of the member to see that all sections of this form are complete, all requested documentation provided, and the form returned to the plan office at **6700 West Broadway, Suite B, Brooklyn Park, MN 55428, Ph. (763) 493-8830 or (800) 368-9045 or via email to claiminfo@ibew292benefits.com.**

1. Member Name: _____
2. Member ID No.: _____
3. Patient's Name: _____
4. Patient's DOB: _____
5. Date(s) expenses occurred: _____
6. Date payment made: _____
7. Amount of reimbursement requested: _____
8. Description of reimbursement requested: _____
   _____
9. Provider Name: _____
10. Provider Address: _____
11. Provider ID or NPI number: _____

READ AND INITIAL EACH LINE:

_____ I have attached all invoices, bills, or statements supporting the claim. For all claims that have been paid, I have identified method of payment and provided proof of payment, including receipts or copies of checks.

_____ I have attached an itemization of the source of the reimbursement that includes all procedure and diagnostic codes, if applicable.

_____ I understand that it is my responsibility to provide all required information to establish the claim for reimbursement.

I hereby certify to I.B.E.W. 292 Health Care Plan that the above statement is true. I understand that any fraudulent statement or omission of material information on this submission will result in the denial of any requested reimbursement and may result in the termination of coverage in the I.B.E.W. 292 Health Care Plan for a period of up to one year.

_____ _____
SIGNATURE DATE

Date received by the I.B.E.W. 292 Benefit Office _____

Note: All incomplete forms will be returned.