**BRICKLAYERS AND ALLIED CRAFTWORKERS**
**LOCAL #2 NY JOINT BENEFIT FUNDS**
**300 Centre Drive, Albany, NY 12203**
**Office # 800-664-8314 / FAX # 518 456-4431 / Website www.bac2funds.com**

# HEALTH REIMBURSEMENT ACCOUNT CLAIM FORM

- For each claim submitted, you must complete the back of this form and include the required documentation, to receive your reimbursement.
- NEW - For over-the-counter reimbursements you must provide receipts showing the expense(s). If your receipt certifies the expense(s) are qualified under HRA, HSA, FSA plans, you can simply list this total amount (per receipt); if it does not, you must list each item separately on the back of this form and highlight or mark the item on the actual receipt.
- You must have a minimum of $ 1,500 in your account to be reimbursed.
- Claim(s) must be at least $ 250 in aggregate; Claims under $250 will be reimbursed semiannually in March and September.
- Proof of payment is required for all items and all reimbursements must be within 5 years from the date of service.

**MEMBER NAME:** ______________________________ **PHONE #:** _________________

**SOCIAL SECURITY #:** ___________________________

**ADDRESS:** ___________________________________________________________________

___________________________________________________________________

**Payment of claims is subject to the terms and conditions in the Health Funds SPD.**

---

***I herby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse the Fund and\or the administrator to the extent of an overpayment, which is in excess of the amounts payable under the plan.***

***ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY AGENCY OR ADMINISTRATOR FILES A STATEMENT OF CLAIMS CONTAINING ANY FALSE, INCOMPLETE INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.***

**MEMBER SIGNATURE:** _______________________________ **DATE:** __________

**FOR OFFICE USE ONLY**

**Processed by** ________ **Date** _______ **Total Amt Req.** ________ **Amt approved** _________ **Amt Denied** ________

**Reviewed by** ________ **Date** ________ **Total Amt Req.** ________ **Amt approved** ________ **Amt Denied** ________

**Amount Paid** ________ **Date** ________ **Payable #** ___________

# HEALTH REIMBURSEMENT ACCOUNT FORM

- ***You must attach a copy of the bill(s) you are seeking reimbursement for.***
- ***If you also submitted the expense to a carrier(s) for reimbursement, you must attach a copy of the explanation of benefits from the carrier(s) showing the amount paid and/or rejected.***
- ***If you are faxing, you must include both sides of this form.***
- ***If you have additional claims, please list them on a separate sheet of paper and number them accordingly.***
- ***If you are applying for dental or vision reimbursements you MUST COMPLETE the box at the bottom of this page.***

| Patient's Name | Patient's Relationship to Member | Patient's Date of Birth | Date(s) of Service | Dr. Name / Facility / Pharmacy Name | Amount Requested |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |
| 9. | | | | | |
| 10. | | | | | |

I'm applying for reimbursement for **(circle one both) dental / vision** expenses for myself and/or my eligible spouse and/or eligible dependents. I certify to the Fund that I do NOT have any **(circle one or both) dental / vision** insurance or discounts which may have paid some or all of the claims in which I'm seeking reimbursement for.

SIGNED: ______________________________

**TOTAL** __________