IBEW Local 99

Deductible Reimbursement Claim Form

Effective 2/1/2023

Date: _____

Employee Name: _____

Mailing Address: _____

Phone #: _____BCBS RI ID #:_____

(If applicable)

Dependent Name: _____

Relationship: _____ Date of Birth: _____

◯ Explanation of Benefits Provided ◯ Provider Bill/Statement Provided

Provider: _____

Claim Date: _____ Claim Amount: _____

For Office Use Only:

Member Deductible Responsibility:		**IBEW HRA** Deductible Responsibility:	

Date of Payment: _____ Check #: _____

Check Amount: _____total Processed by: _____

____ claim(s)

Statement Mailed ☐