IUOE Local 4 2017 Reimbursement Form

Please print all information clearly and attach an itemized statement with procedure codes, diagnosis, charge, and receipt of payment.

Subscriber Information (Policyholder)

Identification Number	Subscriber's Last Name	First Name	Middle Initial
IUH-			

Address—Number and Street	City	State	Zip Code

Employer's Name
IUOE Local 4

Patient Information

Patient's Last Name	First Name	Middle Initial	Date of Birth: Mo, Day Yr.

Mailing Address—Number and Street (if different from subscriber's)	City	State	Zip Code

Gender
- ❑ Male
- ❑ Female

Claim is for (check one):
- ❑ Subscriber (policyholder)
- ❑ Spouse (of policyholder)
- ❑ Ex-spouse
- ❑ Dependent (up to age 26)
- ❑ Other (specify)_____

Claim Information: Claim is for (check all that apply):

❑ Third-Party-Requested DOT Physical Exam (required information)

Name of Provider	Phone Number	Date of Service

Address	Total Charges

❑ Massage Therapy, Acupuncture, Acupressure, Homeopathic Medicine (required information)

Name of Provider	Phone Number	Date of Service

Address	Total Charges

Certification and Authorization (This form must be signed and dated below.)

I authorize the release of any information to Blue Cross Blue Shield of Massachusetts about my third-party-requested DOT physical exam or massage therapy, acupuncture, acupressure, and homeopathic medicine services. I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services. I understand that Blue Cross may require additional evidence of services and proof of payment before reimbursement is provided.

Patient or Parent of
Minor Child's Signature: _____ Date: _____

Questions?

To verify this reimbursement is within your plan or for further information, please log in to the Member Central website at www.bluecrossma.com/membercentral or call Member Service at the number on the front of your ID card.

Please complete and mail this form to:
Blue Cross Blue Shield of Massachusetts
Local Claims Department
PO Box 986030
Boston, MA 02298

MASSACHUSETTS