



SPECIAL FUND ACCOUNT REIMBURSEMENT REQUEST FORM

Phone (706) 841-7000 • Toll Free (877) 937-9602
Fax: (706) 841-7020 • www.nifmcp.com

Return the completed form by fax to (706) 841-7020, by email to sfa_support@nifmcp.com or by mail to:
NECA/IBEW Family Medical Care Plan
410 Chickamauga Avenue, Suite 301
Rossville, GA 30741

You can request reimbursement for expenses that are reimbursable under applicable federal law from your Special Fund Account (SFA). The expenses must have been incurred by you or a family member who is covered under the Plan as your eligible dependent on or after the date your coverage under the NECA/IBEW Family Medical Care Plan first became effective. Covered expenses include, but are not limited to:

1. Self-payments for active or retiree coverage
2. Deductibles, co-pays, and co-insurance from your regular benefit plan
3. Medical, prescription, dental, or vision expenses not covered by, or in excess of, your regular benefit plan

Only **one patient** can be listed per form. However, claims from **multiple providers can be attached for that one patient**.

Supporting documentation must be submitted with this form. Acceptable supporting documentation includes Explanation of Benefit Statement(s) from any medical, prescription, dental, or vision plan(s) under which you and/or your eligible dependents are covered. If the expense is not covered under your medical, prescription, dental, or vision plan(s), itemized bills from providers or other suppliers for insured expenses would be appropriate. Be sure to retain copies of the supporting documentation for your records.

The patient has medical coverage through the NECA/IBEW Family Medical Care Plan: Yes No

Member Name: _____ SSN or Medical ID: _____

Patient Name: _____ Relationship: _____

Provider Name(s): _____

FUNDS FROM MY SFA SHOULD BE APPLIED IN THE FOLLOWING WAY:

- Reimburse me in the amount of \$_____ per the attached supporting documentation.**
Please note that unless otherwise notified by you, the benefit paid will be the maximum benefit based on the supporting documentation you submitted and your account balance. The amount claimed for reimbursement must be clearly identified on the supporting documentation. **Do not use highlighters.**
- Apply funds toward COBRA payment for the month of _____.**
- Apply funds toward Self-Payment for the month of _____.**
- Automatically deduct funds to be applied toward any future self-payments for short hours.** I acknowledge that such automatic deductions will occur and are non-refundable unless and until I withdraw this authorization in writing and it is received by the Benefit Office.

Note: Any items for which you are reimbursed cannot be claimed as deductions or credits on your federal income tax returns.

By signing the below, I request and am fully responsible for the sufficiency and accuracy of information relating to this reimbursement submission. Enclosed itemized bills, receipts and/or EOBs verifying these expenses is for a service/item provided to me, my spouse or an eligible dependent and has not and will not be reimbursed from any other source. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code and cannot be claimed as deductions on my personal income tax.

Member Signature: _____ **Date:** _____