NORTHEAST CARPENTERS FUNDS

Re: Request for Assignment of HRA Claim

Dear Participant:

Records reflect that you contacted the Northeast Carpenters Health Plan to request that the Fund use amounts in your Health Reimbursement Account (HRA) to pay an Eligible Medical Expense incurred by you or your eligible Dependent directly from the Fund to a provider. **It is important that you read this entire letter. Your failure to provide any of the information required by this letter, or to properly complete the enclosed Assignment Claim Form (Form) may delay the processing of your request or your request may be denied.**

In all cases, services must be rendered by the provider prior to any reimbursement.
****Reimbursements can only be made up to the available amount in your HRA account.****

Under the Fund's Plan of benefits, claims for services rendered in excess of $600.00 or more to a single provider may be paid directly from the Fund to the provider of services. In order for the Fund to pay a claim, you must complete the enclosed Form and return it to the Fund Office. In addition to the completed Form, you must provide the following:

1. An itemized bill for completed services on the provider's official letterhead. The bill must include the patient's full name and date of birth; the name, address, and phone number of the provider; a description of the services provided and a valid procedure code for each service; a description of the patient's diagnosis and a valid diagnosis code; the date on which services were rendered; and the provider's charge for each service.
2. An explanation of benefits from the patient's insurance company
3. A W-9 Form that is completed by the provider. A blank W-9 Form has been enclosed for your use.

This information should be sent to the Fund Office at the following address:

Northeast Carpenters Funds
Raritan Plaza II
PO Box 7818
Edison NJ 08818-7818.

If you have any questions, please contact the Fund Office at 732-417-3900.

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Payment Assignment Claim Form

Participant's Information: **ID #:** _____

Participant's Full Name:_____

Participant's Address:_____

Participant's Telephone No:_____ **Participant's DOB:** _____

Patient's information:

Patient's Full Name: _____

Patient's Address: _____

Patient's Telephone No: _____ **Patient's DOB:** _____

Patient's Relationship to Participant:_____

Provider's Information:

Full Name of Provider: _____

Provider's Address:_____

Provider's Telephone No:_____ **Date of Service:** _____

Description of the Services Provided:_____

_____

Amount Billed for services completed by the Provider: $_____

I hereby authorize the Northeast Carpenters Fund to pay the provider identified in this Form for the Eligible Medical Expense described above. I understand that the amount paid by the Fund will be deducted from the balance of my HRA, subject to availability. I understand that by signing this Form, it does not guarantee that the Fund will pay the claim identified above. The Fund will review my request and pay the claim to the extent consistent with the terms of the Fund's Plan of benefits and applicable law; at the time my claim is made. If the Fund issues payment and it is subsequently determined that such claim is not an Eligible Medical Expense or is otherwise not eligible for reimbursement, for whatever reason, I agree to repay the Fund the full amount paid by the Fund. Nothing in this assignment designates the provider identified above as my authorized representative for any purpose under law.

Patient's Signature:_____ **Date:**_____

Participant's Signature (if patient is under age 18):_____

91 Fieldcrest Avenue, Raritan Plaza II 3rd Floor, Edison, NJ 08837 ● P.O. Box 7818, Edison, NJ 08818-7818
Phone 732-417-3900 ● Fax 732-417-0919 ● ncf.carpenters.fund