Tri-County Building Trades Health Fund

3150 US Rt. 60
Ona, WV 25545

REIMBURSEMENT CLAIM FORM
(Gym membership, Dental, Vision, Hearing, and QRE)

Instructions: Check off the type of reimbursement you are requesting. Please complete **ONE FORM per patient**, along with the following information:

Reimbursement for:	**Requirements:**
☐ Gym Memberships	Active Employees only: Copy of your Gym Membership receipt from a recognized gym or fitness facility, maximum reimbursement amount is $200 **Receipt must include the date the membership is for and name of member**
☐ Dental Services	A copy of the itemized billing, this billing must include the date of service, procedure code for services performed as well as the patient's name. **Orthodontic services will be paid for after services are rendered.**
☒ Vision Services	A copy of the itemized billing, this billing must include the date of service, procedure code for services performed as well as the patient's name.
☐ Hearing Services	A copy of the itemized billing, this billing must include the date of service, procedure code for services performed as well as the patient's name.
☐ QRE (Qualified Medical Reimbursement)	Medical, Dental, Vision and Prescription reimbursements for IRS allowable services that are either NOT covered under your other benefits OR you wish to have paid out of your QRE. You may also elect to use these funds for your self-payments.

PLEASE NOTE: **Allow up to 30 business days for reimbursement.**

Member's Name: JASON Newman Member's SS# or Alternate ID: 284865819

Address: 161 E. Archwood Ave Akron OH 44301

Phone Number: (Home) 330-607-1986 (Work) 330-773-5198

Patient Name: Keri Newman Relationship: Wife

Type of Service	Provider Name	Date of Service	Amount of Claim
Vision	Kaster Eye Clinic	10 / 13 / 22	279.00
		/ /	
		/ /	
		/ /	
		/ /	

By signing this form, I understand that benefits shall be paid in accordance with the Tri-County Building Trades Health Fund Account requirements and limitations established by the Board of Trustees. (See the reverse side of this form for a brief description of covered benefits).

Member's Signature: Jason Newman Date: 10/21/22

(OVER)

RECEIPT

Kaster Eye Clinic
1600 East Turkeyfoot Lake Road
Akron,OH 44312-5365
330.899.7161
www.kastereyeclinic.com

Ms. Keri Newman
161 E Archwood Ave
Akron, OH 44301

Account #: 2929
Patient(s): Newman, Keri

DATE	DOS	PATIENT	ACTIVITY	ID	UNITS	AMOUNT	ADJUST	CREDIT
10/13/22	10/13/22	Keri	S0621 Routine Ophth Ex W/ Refr	BPK	1.0	$99.00	$0.00	
10/13/22	10/13/22	Keri	Contact Lens Exam	BPK	1.0	$35.00	$0.00	
10/13/22	10/13/22	Keri	OCT - Posterior Seg-OpticNerve	BPK	1.0	$120.00	$0.00	
10/13/22	10/13/22	Keri	Visual Field Extended	BPK	1.0	$95.00	$0.00	
10/13/22	10/13/22	Keri	AO Night&Day	BPK	2.0	$145.00	$0.00	
10/13/22			Pmt - Credit Card	***		$0.00	$0.00	$279.00
Grand Totals for the Period Beginning 10/13/2022:						**$ 494.00**	**$ 0.00**	**$ 279.00**

Total Receipt Balance: **$ 215.00**

Responsible Balance:	$ 0.00	**Previous Balance:**	$ 0.00
Amount Expected from Insurance:	$ 215.00	**Account Balance:**	$ 215.00

You can pay your statement on our web site www.kastereyeclinic.com Go to "Pay My Bill"

Upcoming Appointments -- None Scheduled

KASTER EYE CLINIC
3705 Massillon Road
Uniontown, OH 44685
330-899-7161

SALE

TID: 0000FWK6 REF#: 00012277
Batch #: 002139 RRN: 286371058378
10/13/22 16:12:58
APPR CODE: 269785
VISA Chip
************1556 **/**

AMOUNT $279.00

APPROVED

VISA DEBIT
AID: A0000000031010
TVR: 80 80 00 80 00
TSI: 68 00

Thank You
Please Come Again

CUSTOMER COPY