

# IUOE Local 4 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	Claim is for (check one):			
<input type="checkbox"/> Male	<input type="checkbox"/> Subscriber (policyholder)	<input type="checkbox"/> Ex-spouse	<input type="checkbox"/> Other (specify) _____	
<input type="checkbox"/> Female	<input type="checkbox"/> Spouse (of policyholder)	<input type="checkbox"/> Dependent (up to age 26)		
Claim Information: Claim is for (check all that apply):				
<input type="checkbox"/> Third-Party-Requested DOT Physical Exam (required information)				
Name of Provider		Phone Number	Date of Service	
Address			Total Charges	
<input type="checkbox"/> 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](http://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