

# ORTHOTIC REIMBURSEMENT CLAIM FORM

**Effective for services rendered on and after April 15, 2009, the Board of Trustees added a Specialized Footwear Benefit to the Southern California IBEW-NECA Active Health Plan (refer to Amendment #41).**

**ELIGIBLE EXPENSES:** Eligible expenses subject to reimbursement shall include expenses for the professional services provided by an orthotist, prosthetist, pedorthist or other provider certified by the American Board for Certification in Orthotics, Prosthetics and Pedorthics when professional services are in connection with the treatment of foot disfigurement. For purposes of this benefit, foot disfigurement means foot disfigurement resulting from cerebral palsy, arthritis, polio, spina bifida, diabetes, accidental injury or abnormal condition.

**INSTRUCTIONS**

1. Complete, date and sign the reimbursement claim form.
2. Attach proof of payment(s).
3. Submit the reimbursement claim form and proof of payment to the address shown below.

Web: [www.scibew-neca.org](http://www.scibew-neca.org)

**PART ONE – PARTICIPANT INFORMATION**

Web: [www.scibew-neca.org](http://www.scibew-neca.org)

Last Name	First Name	SSN																	
Address	City	State	Zip Code					Phone Number											

	Patient's Last Name	Patient's First Name	Total amount billed	Date of service
Self				
Dependent				

**Important: Proof of payment must include the patient's name, date, name and address of service provider, date services are rendered, diagnosis or condition being treated, an itemized listing of services rendered, and payment amount.**

Participant's Signature	Date Signed	Spouse's Signature	Date Signed
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**PART TWO – PROVIDER INFORMATION**

Service Provider	Date of service				
Address	City	State	Zip Code		Phone Number

**RETURN TO:**

**ALLIED ADMINISTRATORS  
P O Box 2500  
San Francisco CA 94126  
Telephone: (800) 736-0401**