



Shared Strength · Trusted Care

# III-A Claim Form

This form must be completed by the member and submitted with an invoice or receipt.  
If you have questions, please call the Benefits Line at 208-938-8199.

III-A Subscriber Name:
Patient Name:
Mailing Address:
City, State, Zip:
Email:
Phone:
III-A Agency/Employer:
Write Check To:

Service Type	Documentation Required		Amount
Acupuncture Reimbursement	Paid Receipt		
Air Ambulance	EOB		
Hearing Aid Reimbursement (pay member)	Paid Receipt		
Hearing Aid Payment Request (pay provider)	Invoice		
*Hearing Protection Reimbursement	Paid Receipt		
Other:			
<b>Total Payment</b>			

**\*Hearing Protection Definition:** Hearing protectors reduce the noise decibel level and the risk of hearing loss.

By signing this form, you attest that you will not seek additional reimbursement, including vouchers or any other form of prescription coupons. The signor also attests that the submitted invoice has been paid in full.

Signature:	Date:
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**Submit completed claim form and invoice or receipt to:**

**Email:** claims@iii-a.org

**Fax:** 208-575-6423

**Mail to:** III-A, Attn: Internal Claims, PO Box 190477, Boise, ID 83719