



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.

Claim Recipient Name:
III-A Member's Employer:
Write Check To:
Mailing Address:

Service Type	Documentation Required		Amount
Acupuncture Reimbursement	Paid Receipt	<input type="checkbox"/>	
Hearing Aid Reimbursement (pay member)	Paid Receipt	<input type="checkbox"/>	
Hearing Aid Payment Request (pay provider)	Invoice	<input type="checkbox"/>	
*Hearing Protection Reimbursement	Paid Receipt	<input type="checkbox"/>	
Weight Management Compound Reimbursement Behavioral Program Participation: <input type="checkbox"/> Wondr <input type="checkbox"/> Health Coaching	Itemized Paid Receipt, Prescription that Includes Weight and Height	<input type="checkbox"/>	
CPAP/BiPAP Machine Reimbursement	Itemized Paid Receipt, Prescription	<input type="checkbox"/>	
CPAP/BiPAP Supplies Reimbursement	Itemized Paid Receipt, Prescription (for machine on file)	<input type="checkbox"/>	
Frames/Contacts (for Vision C-0+ plan)	Itemized Paid Receipt	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	
Total Payment			

***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 to:

Email: claims@iii-a.org

Fax: 208-575-6423

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