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	❑	
Hearing Aid Reimbursement (pay **member**)	Paid Receipt	❑	
Hearing Aid Payment Request (pay **provider**)	Invoice	❑	
*Hearing Protection Reimbursement	Paid Receipt	❑	
Weight Management Compound Reimbursement	Itemized Paid Receipt (from a III-A approved compound pharmacy)	❑	
CPAP/BiPAP Machine Reimbursement	Itemized Paid Receipt, Prescription	❑	
CPAP/BiPAP Supplies Reimbursement	Itemized Paid Receipt, Prescription (for machine on file)	❑	
Frames/Contacts (for Vision C-0+ plan)	Itemized Paid Receipt	❑	
Other:		❑	
		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:

Submit to:
Email: claims@iii-a.org
Fax: 208-575-6423
Mail to: III-A, Attn: Internal Claims, PO Box 190477, Boise, ID 83719

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