Shared Strength · Trusted Care

III-A Specialty Programs Form

This form must be completed by the member and submitted with the required documentation.
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
Bariatric	Itemized Invoice	❑	
St. Alphonsus Maternity Benefit	EOB	❑	
Wig	Paid Receipt	❑	
Air Ambulance (family)	EOB	❑	
Specialty Medication	Signed Claim Form	❑	
Infusion (*Mileage/Travel)	Paid Receipt	❑	
Behavioral Health (*Mileage/Travel)	Paid Receipt	❑	
Mileage/Travel Mileage details: (location/miles) _____	Paid Receipt(s)	❑	
Other:		❑	
		Total Payment	

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