Shared Strength · Trusted Care

Inpatient Behavioral Health Program Reimbursement

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.

Service Type	Documentation Required		Amount
Inpatient Facility: Deductible and Out-of-Pocket cost (reimbursed after completion of program)*	Itemized Receipt/Claims Itemization	❑	
Travel Costs – including 1 companion**	Plane Ticket Receipt/Ground Transportation Mileage Form	❑	
Lodging – one overnight stay if necessary	Receipt	❑	
Other:		❑	
		Total Payment	

***If ½ is required upfront reimbursement will be completed with receipt

**III-A will reimburse the lesser of either the plane ticket or ground transportation

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

By signing this form, you attest that you will not seek additional reimbursement. 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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