INSTRUCTIONS FOR FILING A MENTAL HEALTH/SUBSTANCE ABUSE CLAIM

Check first with your local union office if they participate in the IMPACT mental health/substance abuse benefit as not all local's participate.

Note that the treatment facility must be Licensed, Accredited and recommended by the Employee Assistance Plan (EAP), MAP or RAB co-chairs. If not, the claim will be denied. If there is no EAP, the treatment facility is required to advise BMGI weekly of the person's treatment and compliance.

You cannot collect unemployment while receiving this benefit

☐ **Review your claim and direct deposit forms carefully and gather banking document**
- Be sure ALL information in Section A, B, and C is complete BEFORE sending it in

☐ **Sign the claim & the Direct Deposit agreement form**
- The claim form must be signed by the ironworker, the local, and attending physician

☐ **Include your contact information. Print Legibly or complete digitally (preferred)**
- Ensure your address, **email address (required),** and phone number are legible

☐ **When the claim and the IMPACT Direct Deposit Agreement are complete,** be sure to ALSO attach a copy of a voided check/your own bank's direct deposit form,THEN send ALL documents to IMPACT@BMGIWEB.COM

☐ **Verify that your claim form was submitted properly**
Be sure the physician or the Local submits the fully completed claim form if they are sending it in. If the local section is not completed, ask your Dr. to send it to your local

☐ **Check your email (and mail)**
- BMGI will EMAIL (check spam folder) you if ADDITIONAL information is NEEDED.
- EOBs/CLAIM DECISIONS are emailed Wednesdays from **awsrelay@bmgiweb.com** **Emails are secure so they must be opened within 24 hours.**
- Year-end 1099s will be MAILED through the US Post Office.

☐ **If BMGI notifies you that info was requested from the doctor, contact him**
- Be sure your physician's office promptly completes and returns requested info to BMGI

☐ **Apply for any Local Union, City, State or Federal Gov't benefits you are eligible for**
- BMGI MUST HAVE proof of this information in order to calculate your benefit.

☐ **BMGI will ask your LOCAL to verify eligibility on the date of your injury**
- Confirm you are eligible as a International Association of IW

Email: IMPACT@bmgiweb.com

Mail: IMPACT Off-the-Job Accident Plan

625 Enterprise Drive Oak Brook, IL 60523

Phone/Fax: 630-828-7000

IMPACT Mental Health/Substance Abuse Plan

WEEKLY TIME LOSS CLAIM FORM - SEE INSTRUCTIONS

625 Enterprise Drive • Oak Brook, IL 60523 • Phone 630-828-7000

Administered by Benefits Management Group, Inc. (BMGI)

RETURN COMPLETED FORM
IMPACT@bmgiweb.com or
Fax or Text 630-828-7000

ALL EOB'S/CLAIM DECISIONS are emailed from awsrelay@bmgiweb.com on Wednesdays. CHECK YOUR SPAM FOLDER

☐ Initial request for benefits ☐ Supplemental information on active time loss claim ☐ Check here if your address is new

SECTION A – PLEASE PRINT LEGIBLY TO BE COMPLETED BY THE IRONWORKER

IRONWORKER NAME	SOCIAL SECURITY NO. - -	BOOK NO.	DATE OF BIRTH	GENDER
HOME ADDRESS INCLUDING CITY – STATE - ZIP			LOCAL UNION NO.	
MOBILE PHONE NO.	EMAIL ADDRESS		ARE YOU RETIRED	

Who recommended the Treatment Facility ___EAP/MAP ___ RAB Co-Chairs __Other

ARE YOU PARTICIPATING IN YOUR LOCAL'S EAP or MAP YES / NO

NAME & PHONE NUMBER of the EAP / MAP (Employee Assistance Plan / Medical Assistance Plan

Is the Treatment Facility an In Network Provider your health insurance plan YES / NO

HAVE YOU FILED FOR WORKERS' COMPENSATION BENEFITS? YES / NO

HAVE YOU FILED FOR UNEMPLOYMENT BENEFITS? YES / NO

ARE YOU CURRENTLY RECEIVING UNEMPLOYMENT BENEFITS? YES / NO

IF CURRENTLY RECEIVING UNEMPLOYMENT, WHAT IS THE DATE AND GROSS AMOUNT OF YOUR LATEST UNEMPLOYMENT CHECK

NAME OF YOUR DOCTOR _____ DOCTOR'S PHONE NO. _____

NAME, ADDRESS and Phone # of TREATMENT FACILITY

DATE ENTERED FACILITY _____ DATE DISCHARGED _____

"I hereby authorize any Dentist, Physician, Hospital, Pharmacy, Treatment Facility, Insurance Company, Employer, Health Plan Administrator or Local Union Organization to release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable including disability or employment related information concerning this claim to Benefits Management Group, Inc. or its authorized agent for the purpose of validating and determining benefits payable in connection with this claim. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request."

SIGN HERE► _____ _____

IRONWORKER SIGNATURE DATE SIGNED

SECTION B – PLEASE PRINT LEGIBLY TO BE COMPLETED BY ATTENDING PHYSICIAN (MD)

PATIENT'S NAME	AGE	IS PATIENT PREGNANT? YES / NO
DIAGNOSIS (**ICD10**) CODES		IF HOSPITALIZED, DATE OF ADMISSION
IS CONDITION RELATED TO EMPLOYMENT? YES / NO		
DESCRIBE THE CONDITION BEING TREATED		
DATE FIRST CONSULTED FOR THIS CONDITION:		IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES / NO NEXT APPOINTMENT DATE: _____
IS PATIENT **UNABLE TO PERFORM THE DUTIES** OF AN IRONWORKER WITH THIS CONDITION YES / NO		
PATIENT IS CONTINUOUSLY UNABLE TO WORK FROM: _____ **TO**: _____ **TBD IS NOT ACCEPTABLE FOR ENDING DATE**		

DATE	PHYSICIAN'S NAME (PLEASE PRINT)	SIGNATURE **X**	DEGREE
STREET ADDRESS INCLUDING CITY – STATE – ZIP		PHONE	

PHYSICIAN, PLEASE COMPLETE THIS SECTION AT FOLLOW UP APPOINTMENT
DATE OF FOLLOWUP: _____

IF PATIENT IS RELEASED TO RETURN TO WORK, PLEASE PROVIDE THE DATE S/HE MAY RETURN TO WORK:	IF PATIENT IS **NOT** RELEASED TO RETURN TO WORK, PLEASE PROVIDE THE DATE OF THE NEXT APPOINTMENT:
PHYSICIAN SIGNATURE	

SECTION C PLEASE PRINT LEGIBLY TO BE COMPLETED BY THE LOCAL UNION OR WELFARE PLAN(not the member)

LOCAL UNION NO: _____ REGION/RAB: _____ HOURLY RATE: $_____ BASIC GROSS WEEKLY EARNINGS: $_____

IS THE CLAIMANT A MEMBER OF THE IRON WORKERS INTN'L UNION YES / NO		IRONWORKERS LAST EMPLOYER:
LOCATION/STATE OF LAST JOBSITE:	DATE LAST WORKED:	DATE RETURNED TO WORK, IF KNOWN:
DOES THIS LOCAL/HEALTH PLAN OFFER A LOSS OF TIME BENEFIT? YES / NO		DOES THIS LOCAL/HEALTH PLAN OFFER MATERNITY LEAVE? YES / NO
WEEKLY AMOUNT FROM UNION: $	WEEKLY AMOUNT FROM HEALTH PLAN: $	WEEKLY AMOUNT FOR MATERNITY: $
ANY OTHER L.O.T. DETAILS:		

PRINT NAME OF SIGNER _____ PHONE NO. _____ EMAIL _____

SIGN HERE► _____ _____

AUTHORIZED REPRESENTATIVE OF THE LOCAL (NOT THE CLAIMANT) DATE SIGNED

Benefits Management Group, Inc.
https://www.bmgiweb.com/IMPACT

I.M.P.A.C.T BENEFIT PLANS
c/o Benefits Management Group, Inc. (BMGI)
625 Enterprise Drive ♦ Oak Brook, Illinois 60523
IMPACT@bmgiweb.com Phone/Fax: 630.828.7000

I.M.P.A.C.T. REINFORCE OUR FUTURE
https://www.impact-net.org

Direct Deposit Agreement Form

LAST NAME	FIRST NAME	LAST 4 NUMBERS OF SOC. SEC. NO.
HOME ADDRESS INCLUDING CITY – STATE - ZIP		LOCAL UNION NO.
MOBILE PHONE NO.	EMAIL ADDRESS	
BANK NAME	BANK ACCOUNT TYPE ☐ CHECKING ☐ SAVINGS	
BANK ROUTING NO.	BANK ACCOUNT NO.	

In signing this form, I authorize my payment to be sent to the financial institution named above, and if necessary, to electronically debit my account to correct erroneous entries. I am an authorized signer on the account and will notify the IMPACT Office in advance of closing this account.

This authority is to remain in effect until my benefits with I.M.P.A.C.T. OTJA, Mental Health/ Substance Abuse Plan Provision Plan cease.

The completed and signed form, along with one of the below other required bank documents, may be returned via email, fax, or mailed to the address listed above.

_____ _____ / _____ / _____

Signature **Date**

YOU MUST Attach a Voided Check or Direct Deposit Form printed by your bank