



IRONWORKER MANAGEMENT PROGRESSIVE ACTION COOPERATIVE TRUST

IMPACT Reimbursement Form

Owner Controlled Program

Reimbursement Process:

Members participating in the IMPACT Drug Free Workforce Program that are being tested under an owner controlled program (OCP) will be temporarily exempt from IMPACT testing. Members will be identified in the IMPACT database as participating in an owner controlled program. Contractors must ensure Members are testing under a recognized drug testing OCP and the program is pre-approved by IMPACT to qualify for reimbursement.

Contractors will be reimbursed at the cost of the drug test, and/or capped at the maximum rate of \$45.00 per test. Contractors will be required to submit copies of all invoices and proof of payment of those invoices. Contractors must also provide documentation from the testing facility indicating the test result, date of test, and test cost for each Member participating in the owner controlled program.

All reimbursement requests need to be verified and processed by your Third Party Administrator (TPA). IMPACT will reimburse the Contractor directly once this form is completed and approved by the TPA. Contractors must also provide an invoice to IMPACT on company letter head for the total reimbursement request. Contact your TPA Program Coordinator or IMPACT with any questions.

Contractors must fax reimbursement requests along with required documentation to Midwest Toxicology at (317)262-2222 within 60 days of Member's test date to qualify for reimbursement.

Complete pages 1 and 2 and submit it along with required documentation to your TPA for processing.

Local Union No. _____ Contact: _____ Phone # _____

Contractor Name _____ Contact: _____

Address _____

City, State, Zip _____

Phone # _____ Email Address _____

Authorized Signature of Person Completing Form

Date: _____



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Please complete the following information or attach a spreadsheet with required Member information as below for TPA approval

**IMPACT Reimbursement Form
Owner Controlled Program**

Employee Name	Book #	Invoice #	Test Cost	Test Date	Test Result

Third Party Administrator:

Signature of Authorizing TPA Coordinator: _____

TPA Office: _____ **Date:** _____