IRONWORKER MANAGEMENT PROGRESSIVE ACTION COOPERATIVE TRUST

IMPACT Reimbursement Form
Post-Accident

Reimbursement Process:

A Participant may be tested Post-Accident if they are a direct or indirect cause of accident or injury to persons or property. It is always first priority to treat a Participant's injuries and then get a drug/alcohol test. A valid drug test can be collected up to 30 hours after the accident and up to 8 hours for a breath alcohol test.

Contractors will be reimbursed at a maximum rate of $45.00 per negative test if using a collection facility that is not on the IMPACT website. Contractors will be required to submit copies of paid invoices from the collection facility for reimbursement. The Member test result information will be required in order to update the IMPACT database.

Contractors can request **cab-packs** that contain IMPACT drug testing procedures to provide to collection facilities used that are not on the IMPACT website. If a cab-pack is used, IMPACT will pay the collection facility directly. If you would like to order cab-packs for your construction sites, please call **800-985-0220** or sap@impact-net.org.

All reimbursement requests need to be verified and processed by your Third Party Administrator (TPA). IMPACT will reimburse the Contractor directly once they receive this form approved by your TPA along with an invoice made out to IMPACT. 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 _____

_____ Date: _____

Authorized Signature of Person Completing Form

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IMPACT Reimbursement Form

Employee Name	Social Security #	Date of Test	Testing Facility Name and Location	Contractor or Facility Invoice No.	Project Name and Location

Please submit Contractor and drug testing collection facility invoices.

Third Party Administrator:

Signature of Authorizing TPA Coordinator: _____

TPA Office: _____ **Date:** _____