

**PLUMBERS & STEAMFITTERS LOCAL 47 OF NORTHWEST PENNSYLVANIA WELFARE FUND
MEDICAL REIMBURSEMENT ACCOUNT Request for Reimbursement**

NO YES (Claim Resubmission)

EMPLOYEE INFORMATION (*Indicates Required Information)					
SOCIAL SECURITY NUMBER*		LAST NAME*	FIRST NAME*		M.I.*
HOME ADDRESS			CITY	<input type="checkbox"/> Check if address is new	
STATE	ZIP CODE	HOME PHONE		WORK OR CELL PHONE	

CLAIM FOR UNREIMBURSED HEALTH EXPENSES (ATTACH SUPPORTING DOCUMENTATION)				
DATE EXPENSE INCURRED	NAME OF SERVICE PROVIDER	EXPENSE DESCRIPTION	PERSON FOR WHOM EXPENSE INCURRED	\$ AMOUNT OF REIMBURSEMENT REQUESTED

CLAIM FOR SELF PAY, COBRA OR RETIREE PREMIUMS (INDICATE WHICH TYPE)			
PLEASE SELECT ONE: <input type="checkbox"/> COBRA <input type="checkbox"/> Personal Contribution Premiums	DATE		AMOUNT OF REIMBURSEMENT REQUESTED
	FROM	TO	

EMPLOYEE SIGNATURE REQUIRED - READ CAREFULLY	
<p>The undersigned participant in the Medical Reimbursement Account (MRA) certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the MRA with respect to such expenses. The undersigned fully understands that he/she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim. The undersigned also acknowledges that the reimbursements hereby requested have not been and are not reimbursable under any other coverage. I have read and understand the important information on the reverse side of this form. I understand that any amounts reimbursed may not be claimed on my or my spouse's tax returns.</p>	
EMPLOYEE SIGNATURE (Required)	DATE

Remember: Claim must be submitted with itemized receipts and EOBs. Please send completed form along with all required documentation to:
 Plumbers & Steamfitters Local 47 of Northwest Pennsylvania Welfare Fund
 1200 Three Gateway Center
 Pittsburgh, PA 15222



IMPORTANT INFORMATION REGARDING REIMBURSEMENTS

Please fill out the form completely using a separate line for each individual covered expense. Do not lump expenses together. Sign and date the bottom of the form and keep a copy of the completed form and all attached documentation for your records. An incomplete form or missing documentation may result in a delay or denial of reimbursement. **All information must be complete prior to the reimbursement filing deadline in order to be considered.**

PARTIAL REIMBURSEMENT: In the event that a claim is only partially reimbursed due to insufficient Benefit Credits available, unpaid balances from the partially reimbursed claims will be eligible for future reimbursement.

TYPE OF SUPPORTING DOCUMENTATION

▪ **EOBs** - For expenses covered by the Plumbers & Steamfitters Local 47 of Northwest Pennsylvania Welfare Fund or other health care plan you must submit those expenses under the health care plan first. A copy of the Explanation of Benefits (EOB) Statement which explains the amounts paid and not paid by the health care plan must be attached to this form. For copies of EOBs from Highmark for the Health and Welfare Fund you can contact Highmark at 1-800-241-5704. If the expenses are covered through secondary coverage by another health care plan, you must attach EOBs from all health care plans.

▪ **Itemized Statements or Receipts** - For expenses for services or supplies not covered by the Health and Welfare Fund for other health coverage (such as hearing aids, Lasik vision surgery and other vision expenses) you must provide an itemized statement or receipt from the provider which contains all of the following:

- | | |
|---|---|
| <input type="checkbox"/> Name of person receiving the service | <input type="checkbox"/> Amount charged |
| <input type="checkbox"/> Nature of service or supplies | <input type="checkbox"/> Indication that payment was made |
| <input type="checkbox"/> Name and address of service provider | <input type="checkbox"/> Date service was rendered |

▪ **Retiree/Self-Pay/COBRA Premiums** - No documentation is required to be included with requests for reimbursement of premiums paid to the Health and Welfare Fund. Claims will be matched to Fund Office records.

Note: Balance forward statements, cancelled checks or credit card receipts are not acceptable as documentation of a covered expense. However, cancelled checks and credit card receipts can be submitted along with an itemized statement to show proof of payment.

COVERED EXPENSES INCLUDE:

- Expenses for services or supplies which are covered under the Health and Welfare Fund, but are the financial liability of the participant as a result of the application of deductibles, coinsurance or maximum benefit limitations.
- Premiums paid to the Health and Welfare Fund for Retiree, Self-Pay or COBRA coverage
- Care - The cost of special hand controls and other special equipment installed in a car for the use of a person with a disability.
- Elastic hosiery (by prescription).
- Hearing Aids, related exams and batteries.
- Orthopedic Shoes and Arch Support (with letter from physician).
- Stop-Smoking Programs, excluding amounts paid for drugs that do not require a prescription, such as nicotine gum or patches.
- Substance Abuse Treatment
- Telephone (TTY/TDD) equipment for the hearing-impaired - purchase and repair.
- Therapy - including speech and occupational therapy. Also includes costs for "patterning" exercises given to mentally retarded children.
- Prescription Vitamins.

IMPORTANT LIMITATIONS ON COVERED EXPENSES:

- As required by Federal law, to be eligible for reimbursement under this benefit, all expenses must not have been reimbursed or be eligible for reimbursement under any other health plan coverage or a Flexible Spending Account; and
- The Covered Expense must have been incurred while the person receiving the service or supply was eligible for benefits under the Plumbers & Steamfitters Local 47 of Northwest Pennsylvania Welfare Fund; and
- Proper documentation of the expense and payment must be provided.
- Your Medical Reimbursement Claims may be submitted in the year in which they are incurred and up to one additional year.