PIPE INDUSTRY HEALTH & WELFARE FUND OF COLORADO

Health Reimbursement Account (HRA) Claim Form

Please follow these steps to ask us for payment. If you don't fill in all the required information and sign the form, we won't be able to pay you.

Employee Name (Last, First, MI)	Social Security No.	Date of Birth	Local No.
Address	**City**	**State**	**Zip Code**

Health Reimbursement Account Claims

Please include appropriate documentation required by your employer plan with this completed claim form as follows:
Provide the insurance payer's Explanation of Benefits Statement. An itemized statement must include the provider name/address, patient name, description of the type of service provided, date the service was provided (not when you paid or were billed), and the dollar amount. Prescriptions require the pharmacy receipt, pharmacy printout, or the mail-order itemized statement.

Note: Examples of unacceptable documentation include canceled checks, credit card receipts, balance forward/amount due/paid-on-account statements, pre-treatment estimates or statements for future dates of service.

Date of Service(s)	Health Care Provider	Description of Expense	Patient Name	Patient Date of Birth	Amount Requested
				Total	

I declare these expenses are eligible healthcare expenses for myself, my eligible spouse, or tax-eligible dependents as outlined in my plan documents. I have attached an Explanation of Benefits or itemized receipt, according to the Internal Revenue Service (IRS) rules, these expenses qualify to be excluded from my federal taxable wages and repaid to me. I haven't already requested repayment for these expenses. I haven't received payment from any other source, nor do I expect to. I agree to notify the Fund Office immediately if I receive payment from another source for any of these expenses. I agree that I will not deduct these expenses from my federal, state or local income tax returns.

I understand a claim will only be processed with a completed and signed claim form and correct documentation.

SIGN HERE ➔ ➔ Employee Signature _____ Date _____

FAX TO:
Attention: Fund Office
1-833-263-8956
COVER PAGE RECOMMENDED

MAIL TO:
P.I.A.C, LLC
1391 Speer Blvd. Suite 450
Denver, CO 80204

ONLINE VIA WEX HEALTH:
pipeindustrymbr.lh1ondemand.com

QUESTIONS?:
Please call the Fund Office
Toll-Free 800-257-2168