Member Reimbursement Form

B400

Plumbers and Pipefitters Local 520
P.O. Box 1889
Troy, MI 48099-1889
(717)-565-1101 TOLL FREE (833)-263-5750

☐ Chiropractic ☐ Vision Care ☐ Safety Glasses ☐ Hearing Aids

Member's Name: _____ Member's SS#: _____

Address: _____

Phone Number: _____

Patient Name: _____ Relationship: _____

EXPENSES			
Provider of Service	Date of Service	Patient Name	Charged Amount

PLEASE ATTACH A COPY OF YOUR ITEMIZED STATEMENTS FROM EACH PROVIDER.

EMPLOYEE CERTIFICATION

I am requesting reimbursement of the above listed amounts. I certify that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred (i.e., services were provided) during a period while I was covered under the Plumbers and Pipefitters Local 520 Health and Welfare Fund with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. I fully understand that I am responsible for the sufficiency, accuracy of all information relating to this claim which I am providing, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan. I further understand that no medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

Employee Signature: _____ Date:_____

***NOTE: ANY ITEMS FOR WHICH YOU ARE REIMBURSED CANNOT BE CLAIMED AS DEDUCTIONS OR CREDITS ON YOUR FEDERAL INCOME TAX RETURNS.**

Mail to:
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