PIBF

Health Reimbursement Arrangement (HRA)
Claim Form

EMPLOYEE NAME: _____ PIBF MEDICAL U.I.D.# _____

PLEASE CHECK TYPE OF COVERAGE: ☐ *ACTIVE* OR ☐ *RETIREE*

PHONE # _____ E-MAIL: _____

PATIENT NAME: _____

(Complete a separate form for each covered family member.)

Healthcare Expense Claims

Service Dates	Name of Service Provider / Pharmacy	Claim No. / Expense Description	Member Balance
		Total	$ 0.00

Reminder: If you do not provide the PIBF claim number, you MUST attach a copy of the PIBF Explanation of Benefits. You MUST attach the pharmacy receipts for RX reimbursements.

_____ _____

Employee's Signature Date

Mail or Fax Claim Form and Explanation of Benefits to:
Pipeline Industry Benefit Fund
P.O. Box 470950, Tulsa, OK 74147-0950
Fax: 918-280-4899

You have until April 15th of the following year to file for HRA reimbursement on out-of-pocket expense for the prior year.