PIPELINE INDUSTRY BENEFIT FUND

ACCIDENT INFORMATION CLAIM FORM

THIS FORM IS TO BE COMPLETED BY THE PIBF MEMBER OR DEPENDENT IN THE FOLLOWING INSTANCES:

☐ A recent claim has been filed by a provider to PIBF with a diagnosis that indicates some type of accident or injury.
☐ More information is required in order to complete processing of your claim.

THIS INFORMATION REQUIRES YOUR IMMEDIATE ATTENTION. COMPLETE ENTIRE FORM AND RETURN TO PIBF. DO NOT DISCARD.

Patient Name _____ Birthday _____ ☐ Male ☐ Female

Does aliment result from the patient's occupation? ☐ Yes ☐ No If you answered "YES" - ALL RELATED CHARGES SHOULD BE FILED WITH THE EMPLOYER'S WORKER'S COMPENSATION INSURANCE CARRIER.

PLEASE NOTE: THE PIBF DOES NOT COVER EXPENSES RELATED TO OCCUPATIONAL INJURIES OR CONDITIONS.

Nature of ailment: _____

Is ailment due to injury? ☐ Yes ☐ No If "Yes", date of injury. _____ A.M ☐ P.M. ☐

*Where it happened: _____

*How it happened: _____

*In order to a avoid delay in processing your claim, these 2 lines must be filled out. State if injury/illness is unknown, happened over time, result of old injury/illness, etc.

If the above referenced injury has occurred as the result of a **Motor Vehicle Accident**, the PIBF must receive, along with this Accident Claim Form, a copy of the Police/Accident Report for our records. If Third Party Insurance is involved, a signed Reimbursement Agreement is also required before claims can be reprocessed. If above referenced injury is the result of a **Physical Altercation** a copy of the Police Report will be required along with this form for our records.

Is there other insurance that would be responsible for payment of these medical expenses (such as liability, homeowner's liability, auto insurance or any other responsible third party source)? ☐ Yes ☐ No

If illness, date it began? _____ Last full day worked? _____ Day returned to work? _____

Date of FIRST treatment _____ Name and Address of your present physician. _____

If applicable, was a Police Report filed at the time of the MVA or Altercation? _____

OTHER COVERAGE Are you or any member of your family covered by other health insurance? ☐ Yes ☐ No

Are you or any member of your family covered by Medicare? ☐ Yes ☐ No

If "Yes" give name(s) of person(s) covered by other insurance _____

Effective date of other coverage _____ ID number of other insurance _____

Please indicate name and phone number of other insurance

****All PIBF Forms may be printed from the PIBF website. Go to: pibf.org, H & W Benefits, PIBF Forms****

AUTHORIZATION **Must be signed by patient. If patient is under 18, the parent or legal guardian should sign for patient.**

I hereby authorize any doctor, hospital or medical service provider to furnish and disclose all known facts concerning this claim. A copy or photocopy of this authorization shall be as valid as the original.

Signed _____ Date _____

Address _____ City _____ State _____ Zip _____

PIBF Member's Identification No. _____ Phone ( ) _____

PIBF Member's Name _____

NOTICE: INFORMATION NEEDED TO COMPLETE PROCESSING IS SUBJECT TO THE TIMELY FILING CLAUSE OF YOUR PIBF PLAN. THE FILING PERIOD FOR CLAIMS AND ANY OTHER RELATED INFORMATION IS ONE YEAR FROM THE DATE OF SERVICE.

RETURN THIS FORM TO:

PIPELINE INDUSTRY BENEFIT FUND, P.O. Box 470950, Tulsa, OK 74147-0950 Ph#: (918) 280-4800 FAX#: (918) 280-4899