PIPELINE INDUSTRY BENEFIT FUND CLAIM FORM

PIBF

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

- TREATMENT OR SERVICE IS RELATED TO AN ACCIDENT AND A FORM HAS NOT PREVIOUSLY BEEN SENT TO PIBF
- YOU HAVE PAID FOR THE SERVICES, AND ARE REQUESTING REIMBURSEMENT FROM PIBF
- THE PROVIDER'S OFFICE DOES NOT FILE INSURANCE CLAIMS FOR YOU
- IF REQUESTED BY THE PIBF OFFICE WHEN MORE INFORMATION IS NEEDED IN ORDER TO COMPLETE PROCESSING OF YOUR CLAIM

CHECK TYPE OF EXPENSE YOUR CHARGES PERTAIN TO

☐ **MEDICAL** ☐ **DENTAL** ☐ **VISION**

PIBF accepts standard or generic insurance forms provided and/or completed by the Medical, Vision or Dental provider. When using **this** PIBF form, answer each question and be sure to attach an itemized statement of charges. This statement should include the complete name and mailing address of the physician, hospital or clinic along with the patient name, date of service, description of service rendered, diagnosis and amount charged for each service.

I hereby apply for benefits resulting from medical expense incurred by ❑ Self ❑ Spouse ❑ Unmarried Child

1. Patient Name _____ Birthdate |__|__|__| ❑ **Male** ❑ **Female**

2. Does ailment result from patient's occupation? ❑ Yes ❑ No If you answered **"yes"** - ALL RELATED CHARGES SHOULD BE FILED WITH THE EMPLOYER'S WORKER'S COMPENSATION INSURANCE CARRIER.
PIBF DOES NOT COVER EXPENSES RELATED TO OCCUPATIONAL INJURIES OR CONDITIONS.

3. Describe nature of ailment _____

4. Is ailment due to injury? ❑ Yes ❑ No If "Yes," date of injury |__|__|__| **A.M** ❑ **P.M.** ❑

Where it happened _____

How it happened _____

Is there any 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

5. If illness, when did it begin? |__|__|__| Last full day worked |__|__|__| Returned to work |__|__|__|

6. Date of FIRST treatment |__|__|__| Name & address of your present physician _____

7. 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 _____

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

AUTHORIZATION FOR DIRECT PAYMENTS OF BENEFITS

(Do not sign (below) if provider has been paid)

I authorize payment directly to the provider of service

Signed: _____ Date |__|__|__|

Notice: If payment is not assigned, an itemized statement and paid receipt must accompany this claim.

MAIL CLAIMS TO:
PIPELINE INDUSTRY BENEFIT FUND
P.O. BOX 470950
TULSA, OK 74147-0950
(918) 280-4800
FED. TAX I.D. #73-0742835

GOLF C-651

Form 101 (Revised 10/07)
F.I.P.

NOTICE - THIS PLAN HAS A 1 YEAR (365 DAY) FILING PERIOD