SOUTHERN CALIFORNIA PIPE TRADES HEALTH & WELFARE FUND
501 Shatto Place, 5th Floor, Los Angeles, CA 90020 | (800) 595-7473 (213) 385-6161 | Fax (213) 487-3640 | www.scptac.org

Health Reimbursement Arrangement (HRA)
REQUEST FOR REIMBURSEMENT FORM

All sections must be completed. Submit this form only if you have $25 or more in expenses for reimbursement.

Supporting documentation for each expense must be provided together with this Request form, describing the expenses and proving that the Participant, eligible Spouse, or eligible Child paid the expenses. Supporting documentation **must** include, but is not limited to:

(1) **An itemized bill describing the services provided, the person to whom the services were provided, the name of the provider, the date of service, and the charged amount;**

(2) **A receipt showing proof of payment; and**

(3) **If applicable, an Explanation of Benefits (EOB).**

PART 1 Patient Information

NAME	
DATE OF BIRTH	*mm/dd/yy* / /
ADDRESS	*Street, City, State, ZIP*
PHONE	( ) -
RELATIONSHIP *(To Participant)*	☐ Self ☐ Spouse ☐ Child
MARITAL STATUS	☐ Single ☐ Married ☐ Divorced

PART 2 Participant & Spouse Information

	PARTICIPANT	**SPOUSE** *(required whether or not spouse is patient)*
NAME		
PARTICIPANT ID	Blue Shield of California **T500** OR Social Security Number - - *(only last four digits required)*	
DATE OF BIRTH	*mm/dd/yy* / /	*mm/dd/yy* / /
ADDRESS	*If different from Patient* *Street, City, State, ZIP*	*If different from Patient and Participant* *Street, City, State, ZIP*
PHONE	( ) -	( ) -
E-MAIL ADDRESS	*(Optional)*	*(Optional)*
EMPLOYER NAME		
EMPLOYER ADDRESS	*Street, City, State, ZIP*	*Street, City, State, ZIP*

PART 3 HRA Reimbursement Procedures

An HRA Allowance may be used to reimburse eligible health care expenses incurred by the Participant, Spouse or eligible Child which are not covered or reimbursed in full by this Plan or any other health plan or insurance policy. Reimbursable expenses are those that constitute "medical care" under Section 213 of the Internal Revenue Code. For example, an HRA Allowance may be used to reimburse the Participant for Plan deductibles, co-payments, and other non-covered expenses for medical, prescription drug, dental, vision, and psychiatric services. An HRA Allowance may also be used to reimburse Subsidized Self-pay premiums, COBRA premiums, other medical plan premiums, Medicare supplemental plan premiums, Medicare Part B or D monthly premiums, and long-term care insurance premiums (but not life insurance premiums). No benefit will be paid from an HRA Allowance in an amount less than $25.00.

To be eligible for reimbursement, a Request for Reimbursement form must be submitted within 24 months after the date of service. **Requests submitted after 24 months will be denied.** Large Requests that were initially filed by the 24-month deadline, but which still had a remaining balance after the HRA Allowance was exhausted, may be re-filed indefinitely as new contributions to the HRA Allowance are received.

PART 4 Reimbursement Information

List the expenses for which you are requesting reimbursement. Include the date of service (date expense was incurred), a brief description of the type of expense (for example, prescriptions, deductibles, co-payments, dental or vision). Each item must be accompanied by proof of payment and documentation of the expense. Please list each expense amount on a separate line. Attach additional pages if needed.

Date of Service	Description or Claim Number	Amount

PART 5 Authorization

I/We hereby certify that the foregoing statements, and any accompanying statements, are true, correct and complete to the best of my/our knowledge. I/We hereby certify that the expenses in question were not reimbursed, and are not otherwise reimbursable, in whole or in part, by this or any other plan. I/We hereby authorize the Health & Welfare Fund to use or disclose the information contained in its files in whatever way deemed necessary for the purpose of determining the reasonableness of any of the expenses submitted herewith or the propriety of this reimbursement. I/We understand that the reimbursement will be payable to the Participant.

I/We certify under penalty of perjury under the laws of the State of California that the patient named above meets all the requirements for eligibility under the Plan.

PARTICIPANT SIGNATURE *Required*	DATE	PATIENT SIGNATURE *Required unless under 18 years of age*	DATE
X		X	