

**PLUMBERS & PIPEFITTERS MEDICAL FUND**  
**7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046**  
**Phone: 1-800-741-9249**

**2023**  
**MEDICAL REIMBURSEMENT ALLOWANCE**  
**HEALTH CARE REIMBURSEMENT REQUEST FORM**

1. Type or print on the Employee Section below.
2. A. Active Members: Accumulate at least \$400.00 in expenses **incurred between January 1 and December 31, 2023** to be reimbursed before submitting a claim to the Fund. Claims that are under \$400 must be submitted after December 31, 2023, but before March 31, 2024.
- B. Retired Members: Accumulate at least \$400.00 in expenses **incurred between January 1 and December 31, 2023** to be reimbursed before submitting a claim to the Fund. Claims that are under \$400 must be submitted after December 31, 2023, but before March 31, 2024. (If you are requesting reimbursement for a self-payment, it is not necessary to submit a copy of your self-payment check.)
3. Supporting documentation **must** accompany this request form. Supporting documentation includes the following:
  - a copy of the **EXPLANATION OF BENEFITS** from Plumbers and Pipefitters Medical Fund.
  - an **ITEMIZED BILL** from the provider
  - acceptable proof that you paid the expenses and they were not reimbursed by this or any other Plan such as a **CANCELLED CHECK, STORE RECEIPT, CREDIT CARD BILL, etc.**
4. Retain copies of supporting documentation for your records, as those submitted to the Fund will not be returned.
5. Send completed claim form and supporting documentation directly to Plumbers & Pipefitters Medical Fund, 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046.

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

**EMPLOYEE SECTION**

NAME	SOCIAL SECURITY NO.	
ADDRESS	PHONE	
CITY	STATE	ZIP CODE

**FUND OFFICE SECTION**

CHECK NO:	AMT:	DATE:	CLAIM NO:
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I certify that either I and/or my eligible dependent(s) have incurred the expenses for which reimbursement is claimed from the Medical Reimbursement Allowance and I further declare that I have not and will not deduct these expenses on my individual Income Tax Return. I understand that I may not assign this payment to another person – the Fund will only make payment to me.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date