

Plumbers & Steamfitters Local 33 Health & Welfare Fund Office

Alternative Treatment Claim Form

PARTICIPANT INFORMATION

Participant Name:		ID Number:	
Patient Name:		Date of Birth:	
Address:	City:	State:	Zip:
Name & Address of Treating Provider:			
Amount Requested for Reimbursement from HRA (proof of payment must be attached):			
Participant Signature:		Date:	

By signing above, I certify that my statements on this Claim Form are complete and true. I certify that this expense, reimbursed for myself, my spouse, or eligible dependents have not and will not be reimbursed under any other Health Reimbursement Account, insurance plan, nor be claimed as an income tax deduction.

TREATING PROVIDER INFORMATION

Treating Provider Name (please print)	Provider Address & Phone Number:	Provider Tax-ID:
Patient Name:		Date(s) of Service:
Diagnosis/Condition being Treated:		
Procedure Code(s)/Details of Service(s) Provided:		Amount (per service):
Treating Provider Signature:		Date:

By signing above, I certify that my statements on this Claim Form are complete and true. I certify that the expense(s) listed have been performed and that I haven't submitted them to any other Health Reimbursement Account, insurance plan, etc.