Plumbers and Pipefitters Local Union No. 94 Health & Welfare Fund

3660 Stutz Drive, Ste. 101
Canfield, Ohio 44406
Phone (800) 435-2388
Fax (248) 731-5603

THIS FORM IS NOT TO BE USED FOR YOUR HEALTH REIMBURSEMENT ACCOUNT (HRA) CLAIMS

DENTAL / VISION REIMBURSEMENT CLAIM FORM

Dental/Vision Benefit Reimbursement Account **E-mail: local94DV@benesys.com**

Instructions: Please complete **ONE FORM per claim/per individual**, along with the following information:

Reimbursement for:

☐ **Dental/Vision Services**

Requirements:

Attach copy of the itemized billing. This billing must include the date of service, procedure code for services performed as well as the patient's name. This is your Dental/Vision Plan that reimburse eligible expenses up to a maximum payment of $2,000 per Family/Per Calendar year.

☐ Dental/Vision balance - Please pay any remaining balance using my MRA funds.

IMPORTANT NOTICE: A submission of a claim that has already been reimbursed under the Dental/Vision Plan may result in the suspension of your Benny Card.

Member's Name: _____ Member's SS# or Alternate ID: _____

Address: _____

Phone Number: (Home) _____ (Work)_____

Patient Name: _____ Relationship: _____

Type of Service	Provider Name	Date of Service	Amount of Claim
_____	_____	_____/_____/_____	_____
_____	_____	_____/_____/_____	_____
_____	_____	_____/_____/_____	_____

By signing this form, I understand that benefits shall be paid in accordance with the Plumbers and Pipefitters Local Union No. 94 Health & Welfare Fund Account requirements and limitations established by the Board of Trustees.
Note: Unreimbursed Dental and Vision expenses are subject to limitations specified in your Summary Plan Description.
(See the reverse side of this form for a brief description of covered benefits)

Member's Signature: _____ Date: _____

*****Not valid unless signed and dated by employee*****

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The Dental/Vision Reimbursement is available to actives, early retirees and retired members and their dependents.

What do I have to do to request reimbursement for my Benefit?

You must send a completed Reimbursement Benefit Claim Form along with the following information attached: (Please Note: BALANCE DUE STATEMENTS ARE **NOT** ACCEPTABLE).

Reimbursement for:	**Information Required**
Dental/Vision Claims	Attach a copy of the itemized billing. This billing must include the date of service, procedure code for services performed as well as the patient's name. This is your Dental/Vision Plan that reimburse eligible expenses up to a maximum payment of $2,000 per Family/Per Calendar year. **Orthodontic services will be paid once services are rendered.**

Where do I obtain Reimbursement Claim Forms?

You may print the **Dental/Vision claims** Reimbursement Form from the **Participant Website: www.UaLocal94Benefits.org**

Click on Documents, select Health Care – Health Care Documents, select **Dental / Vision** Reimbursement Form. You may also contact the Fund office at (800) 435-2388 to have a claim form mailed to you.

Where do I send my Reimbursement claim requests?

You have (3) options to submit your claim(s).

By MAIL:	**By FAX:**	**By EMAIL:**
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Is there a time limit to file for Reimbursement Benefits?

YES: **Dental/Vision claims** must be filed within one year from the date of service.

What information should I keep?

Please keep a copy of all items submitted in case of a Fund Audit or IRS documentation requirement.