Milwaukee County, #714852
Wellness Program
Reimbursement Request

KEYABLE CLAIM

Provider EIN: 06-9000001

Diagnosis Code: **799.99R99**

* Health club membership: **DATE:** From: _____ To: _____
Place of Service: **CL** Procedure Code: **S9970** Total Charge: $_____

* Weight loss membership: **DATE:** From: _____ To: _____
Place of Service: **CL** Procedure Code: **S9449** Total Charge: $_____

Identification Number: _____

Employee Name: _____

Address: _____

_____

Member Name: _____

Relationship (check one): Subscriber _____
Dependent _____

All benefit payments will be sent to the subscriber's address on file.

Certification and Authorization (this form must be signed and dated below)
I authorize the release of information to UnitedHealthcare about my health club and/or weight loss program membership. I certify the information provided is complete and correct and that I have not previously submitted for reimbursement of these expenses.

Subscriber/Member
Signature_____Date_____

Submit this completed form with receipts to: **Springfield Claim Office**
PO Box 30555
Salt Lake City, UT 84130-0555

Milwaukee County Members

Belong to a health club/gym or participating in a weight management program (i.e. Weight Watchers)

Please complete the "Wellness Program Reimbursement Request" Form to obtain up to a $100 reimbursement for you and your dependents on the health plan.

Reimbursement is sent via check from United Health Care.
Mail the form, along with an official receipt from your gym/health club or weight management program, to the address at the bottom of the form. Ask your provider for a receipt breaking out your monthly payments.

- **"Total Charge"- Total you paid for the dates specified. Example, requesting reimbursement for Sept 1st to Dec 31st. Cost per month was $50. "Total Charge"- $200.**
- **"Date" To/From- indicate dates you are requesting reimbursement for. Please note "Dates" cannot cross calendar years. Do not put 'present' or 'current' in the "Dates". Example requesting reimbursement for Sept-Dec. 2015. Put September 2015 – December 2015.**
    - **Future dates cannot be processed. i. .e. Dates of Service 9/1/2015-12/31/2015, the form should be dated and submitted on or after 12/31/2015.**
- **UHC reimburses up to $100 per person on the health plan. If you have a family of four with health club cost $101 or greater, fill out a form for each person indicating Dates of Service and cost broken down my member.**
- **Identification number, your United Health Care Member Number on your Medical ID card.**
- **"Employee Name"- The person who holds the insurance.**
- **The claim turnaround time is about 14 days, with an additional 10 working days for check processing/mailing.**
- **If you do not receive the reimbursement within 45 days from the date you submitted the Wellness Program Reimbursement Request Form, please call the number on the back of your ID card for assistance.**