



\$150 ANNUAL FITNESS REIMBURSEMENT FORM

Employee Address:	Employee Name:	ALT ID/SSN:	Da	te of Birth: <u>/</u>	/ /
Eligible: Memberships to gyms, fitness studios, fitness apps, fitness streaming services; home fitness equipment and wearable devices. Reimbursement up to \$150 dollars MAX per calendar year in total based on qualified receipts. All reimbursements will be made payable and processed under the employee's record. If you have questions, please call the Custome Care number on your card. REQUIRED INFORMATION: Product or Health Facility Name:					
Nome fitness equipment and wearable devices. Reimbursement up to \$150 dollars MAX per calendar year in total based on qualified receipts. All reimbursements will be made payable and processed under the employee's record. If you have questions, please call the Custome Care number on your card. REQUIRED INFORMATION: Product or Health Facility Name: Health Facility Address: Health Facility Phone Number: Number of Pages with Copies/receipts attached: Total Amount submitted for reimbursement: INSTRUCTIONS: Please mail this form with photocopies of dated, proof of payment for health club enrollment. Any reimbursements must be received by UHC by March 31st of the following year. Mailing Address: UnitedHealthcare, P. O. Box 740800, Atlanta, GA 30374-0800. ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATIC OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES. Employee Signature: Date: INTERNAL USE ONLY **FOR PROCESSING USE: Code S9970, Place of Service (POS) is "OL", DX code Z0000, TIN- 0-69000005-00001 **FOR UNITED HEALTHCARE USE ONLY DATE BENEFITS BECAME EFFECTIVE MO. DAY YEAR MO. DAY YEAR MO. DAY YEAR MO. DAY YEAR ACCOUNTED. Emp. Dep. D	Health Club Enrolled Member:		Relatio	nship to EE_	
Product or Health Facility Name:	home fitness equipment and weara calendar year in total based on qua and processed under the employee	ble devices. Reimburseme lified receipts. All reimburs	ent up to \$150 sements will b	dollars MA e made pa	X per yable
Health Facility Address:	REQUIRED INFORMATION:				
INSTRUCTIONS: Please mail this form with photocopies of dated, proof of payment for health club enrollment. Any reimbursements must be received by UHC by March 31st of the following year. Mailing Address: UnitedHealthcare, P. O. Box 740800, Atlanta, GA 30374-0800. ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES. Employee Signature: Date: INTERNAL USE ONLY FOR PROCESSING USE: Code S9970, Place of Service (POS) is "OL", DX code Z0000, TIN- 0-69000005-00001 FOR UNITED HEALTHCARE USE ONLY DATE BENEFITS BECOME EFFECTIVE MO. DAY YEAR	Product or Health Facility Name:				
Number of Pages with Copies/receipts attached: Total Amount submitted for reimbursement: INSTRUCTIONS: Please mail this form with photocopies of dated, proof of payment for health club enrollment. Any reimbursements must be received by UHC by March 31st of the following year. Mailing Address: UnitedHealthcare, P. O. Box 740800, Atlanta, GA 30374-0800. ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES. Employee Signature: Date: INTERNAL USE ONLY FOR PROCESSING USE: Code S9970, Place of Service (POS) is "OL", DX code Z0000, TIN- 0-69000005-00001 FOR UNITED HEALTHCARE USE ONLY DATE BENEFITS BECAME EFFECTIVE MO. DAY YEAR	Health Facility Address:				
INSTRUCTIONS: Please mail this form with photocopies of dated, proof of payment for health club enrollment. Any reimbursements must be received by UHC by March 31st of the following year. Mailing Address: UnitedHealthcare, P. O. Box 740800, Atlanta, GA 30374-0800. ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES. Employee Signature:	Health Facility Phone Number:				
INSTRUCTIONS: Please mail this form with photocopies of dated, proof of payment for health club enrollment. Any reimbursements must be received by UHC by March 31st of the following year. Mailing Address: UnitedHealthcare, P. O. Box 740800, Atlanta, GA 30374-0800. ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES. Employee Signature: Date: INTERNAL USE ONLY FOR PROCESSING USE: Code S9970, Place of Service (POS) is "OL", DX code Z0000, TIN- 0-69000005-00001 FOR UNITED HEALTHCARE USE ONLY DATE BENEFITS BECAME EFFECTIVE MO. DAY YEAR	Number of Pages with Copies/receipts attach	ed:			
Please mail this form with photocopies of dated, proof of payment for health club enrollment. Any reimbursements must be received by UHC by March 31st of the following year. Mailing Address: UnitedHealthcare, P. O. Box 740800, Atlanta, GA 30374-0800. ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES. Employee Signature:	Total Amount submitted for reimbursement:				
Employee Signature:	Please mail this form with photocopies of date be received by UHC by March 31st of the following GA 30374-0800. ANY PERSON WHO KNOWINGLY FILE OR ANY FALSE, INCOMPLETE OR MIS	wing year. Mailing Address: United SS A STATEMENT OF CLAIM CO SLEADING INFORMATION MAY E	Healthcare, P. Ó. NTAINING ANY M BE GUILTY OF A	Box 740800,	Atlanta, NTATION
FOR PROCESSING USE: Code S9970, Place of Service (POS) is "OL", DX code Z0000, TIN- 0-69000005-00001 FOR UNITED HEALTHCARE USE ONLY DATE BENEFITS BECAME EFFECTIVE MO. DAY YEAR Emp. Dep. Emp. Dep. Dep. Dep. Dep. Dep. Dep. Dep. Dep. Dep. Dep. Dep. Dep. Dep. Dep. Dep. De				<u> </u>	
	FOR UNITED HEALTHCARE USE ONLY DATE BENEFITS BECAME EFFECTIVE MO. DAY YEAR MO. DAY YEAR Emp. Dep.	DATE BENEFITS TERMINATED MO. DAY YEAR Emp. Dep.	MO. DAY YEAR	SUFFIX	ACCOUNT DAY YEAR)