Wellness and Preventive Reimbursement Claim Form

Use this form to file claims for out-of-pocket wellness and preventive care expenses.

PART ONE: Your Benefit Information

Date Submitted: _____

Number of Receipts Attached: _____

MEMBER ID / SOCIAL SECURTY NUMBER

PATIENT'S NAME (FIRST AND LAST)

MEMBER NAME

PATIENT'S DATE OF BIRTH (MM/DD/YY) / /

MAILING ADDRESS

PATIENT IS:

☐ MEMBER ☐ SPOUSE ☐ CHILD

(Please use a separate form for each family member.)

CITY STATE ZIP

( )

DAY TIME TELEPHONE NUMBER

The undersigned certifies that the receipts attached herein were received by the undersigned for the member noted above. The undersigned authorizes release of any and all information to the plan administrator for use in connection with the benefit plan program. Information may also be used for other reporting and analysis purposes without identification of the undersigned or the member noted above. The undersigned further authorizes use of such person's member number for identification purposes and further recognizes that reimbursement will be paid directly to the member and assignment of these benefits to a pharmacy or other party is void.

SIGNATURE OF PATIENT, GUARDIAN OR LEGAL REPRESENTATIVE

PART TWO: Your Expense Information - Please see reverse for helpful reminders.

Tape or attach receipts for each expense for which you are seeking reimbursement. Attach itemized billing for all other reimbursement requests.

Please check the appropriate boxes and attach documentation.

- ☐ Aspirin
- ☐ Contraceptive Services
- ☐ Falls Prevention
- ☐ Folic Acid/Daily Supplement
- ☐ Gonorrhea Prevention Eye Medication, Newborns
- ☐ Iron Supplements (Anemia Prevention) in Children
- ☐ Smoking Cessation

Receipt Item #1 **TAPE OR AFFIX RECEIPT** *NO STAPLES PLEASE*	**Receipt Item #2** **TAPE OR AFFIX RECEIPT** *NO STAPLES PLEASE*
Receipt Item #3 **TAPE OR AFFIX RECEIPT** *NO STAPLES PLEASE*	**Receipt Item #4** **TAPE OR AFFIX RECEIPT** *NO STAPLES PLEASE*

HELPFUL REMINDERS

- Completely fill out Part One of the Wellness and Preventive Reimbursement Claim Form and attach your receipts.

- Use a separate form for each family member. Do not attach more than one family member's receipts to one claim form.

- Keep a copy for your records.

- Make sure your prescription receipts show the dates your prescriptions were filled; the name and address of your pharmacy; and the name, strength, quantity, and days supply you received. Your receipts should also show the National Drug Code (NDC) numbers for your prescriptions, your prescription numbers and the amounts you paid for them.

- Please do not staple receipts on the claim forms.

- If you need help or have questions, call the Customer Service number on your ID card, Monday through Friday, 8:30 a.m. – 8 p.m. Eastern Time. A language line is available for translation for most languages.

- Mail your Reimbursement Claim Form to:

Planned Administrators, Inc.
P.O. Box 6702
Columbia, SC 29260