UFCW LOCAL 1776 AND PARTICIPATING EMPLOYERS
HEALTH AND WELFARE FUND

Preventive & Wellness Reimbursement Request

Preventive & Wellness Benefit – If you have an out-of-pocket expense related to preventive or wellness care, such as deductible, copay, or coinsurance, you can submit the expense to the Fund Office, and you will be reimbursed up to $100 per eligible family member per calendar year. For a list of eligible expenses, please see the Wellness Guidelines listed on the back of this form.

Please print all information

Participant information

Participant Name (print) _____ Social Security Number (last 4 digits) _____

Address _____

City _____ State _____ Zip code _____

Work phone (_____)_____ Home phone (_____)_____

E-mail address _____

Patient's First and Last Name	Provider's Name	Type of Service	Date(s) of Service	Amount Paid

Important Information:

- You must attach an itemized bill and receipt for each service included above. Itemized bills must include the patient's full name, the provider's name and address, the date of service, and the procedure code(s), the diagnosis code(s) ("ICD-9 codes"), and the amount billed for services rendered.
- You must be eligible for benefits and enrolled in the Fund's medical coverage, at the time of service.
- Reimbursement Request Forms must be filed no later than 18 months from the date of service.
- Requests for reimbursement cannot be accepted before service has been provided.

Participant signature: _____**Date:** _____/_____/_____

Mail completed form with the appropriate attachments to:
UFCW Local 1776 and Participating Employers
Health and Welfare Fund
3031 B Walton Road
Plymouth Meeting, PA 19462

If you have any questions about this claim form or your benefits, or need assistance in completing this form, contact the Fund Office at 610-941-9400 or toll free at 1-800-458-8618, or fax at 610-941-9602. You can also download this form from our website at **www.ufcw1776benefitfunds.org.**

UFCW LOCAL 1776 AND PARTICIPATING EMPLOYERS
HEALTH AND WELFARE FUND

Wellness Guidelines for All Ages
Eligible Expenses*

	Birth-10 years	11-20 years	21-39 years	40 and older
Routine Office Visit (history and physical)	x	x	x	x
Diabetes screening	x	x	x	x
Cholesterol test (fasting)	x	x	x	x
Pap test/Pelvic Exam (females)		x	x	x
Prostate screening (males 50+, or 40+ if at increased risk)				x
Mammography (females)				x
Other routine preventive and wellness care services	x	x	x	x

*Certain restrictions and/or exceptions apply. If you have any questions regarding your benefits and expenses eligible for the Preventive and Wellness Benefit reimbursement, please contact the Fund Office.