



**PLEASE REVIEW AND LEGIBLY COMPLETE ALL SECTIONS (1-4) OF THIS FORM**

Please Note: COPIES OF ALL BILLS/RECEIPTS MUST BE SUBMITTED WITH THIS FORM IN ORDER FOR YOUR REWARD TO BE CONSIDERED. If you do not have a valid bill/receipt, please contact the provider of service to obtain prior to submitting your reward reimbursement. NOTE: Please submit one rewards request per College Reward Request form. Separate reward requests need to be submitted for each qualified reward request according to your contract. To be eligible for the reward benefit services must be for one of the qualified expenses listed below.

If you have eligibility, benefit or form related questions, please contact customer service using the number listed on the back of your member ID card.

**Univera Fit Dollars  
Reimbursement Form**

Mail completed form and all required information to:

P.O. Box 211256  
Eagan, MN 55121-2656

**SECTION 1**

**INFORMATION REQUIRED FOR REIMBURSEMENT**

COPIES OF ALL BILLS/RECEIPTS FOR QUALIFIED EXPENSES **MUST BE SUBMITTED** WITH THIS FORM IN ORDER FOR REIMBURSEMENT TO BE CONSIDERED. BALANCE BILL, CANCELED CHECKS ETC. ARE **NOT** ACCEPTABLE. BILLS MUST CLEARLY INDICATE **ALL OF THE FOLLOWING**:

1. FULL NAME AND DATE OF BIRTH OF THE PERSON RECEIVING SERVICES
2. NAME AND ADDRESS OF THE INDIVIDUAL OR BUSINESS/ORGANIZATION PROVIDING THE SERVICE(S)

3. DATE FOR SERVICE RENDERED
4. CHARGE FOR SERVICE RENDERED

5. ALL CLAIMS FOR REIMBURSEMENT MUST BE SUBMITTED WITHIN 12 MONTHS FROM THE DATE SERVICES WERE RENDERED IN ORDER TO BE CONSIDERED FOR PAYMENT.

**SECTION 2**

**SUBSCRIBER INFORMATION**

Please enter all information exactly as shown on your ID card

SUBSCRIBER'S LAST NAME		SUBSCRIBER'S FIRST NAME		SUBSCRIBER IDENTIFICATION NUMBER	
ADDRESS-NUMBER AND STREET			CITY	STATE	ZIP CODE
2i-PATIENT'S LAST NAME	2j-FIRST NAME	2k-INITIAL	2L-DATE OF BIRTH ____/____/____ mm dd yyyy	2m-GENDER M F	2n-PATIENT'S RELATIONSHIP TO SUBSCRIBER Self Child Spouse
DATE(S) OF SERVICE	SERVICE INFORMATION			AMOUNT	
From: ____/____/____ mm dd yyyy	<input type="checkbox"/> HEALTH RELATED CLASSES FOR ADULTS S9451/Dx. Z7189 <input type="checkbox"/> WEIGHT MANAGEMENT PROGRAMS S9449/Dx. Z7189 <input type="checkbox"/> HEALTH CLUB/GYM MEMBERSHIP S9446/Dx. Z7189 <input type="checkbox"/> MASSAGE THERAPY 97124/Dx. Z7189 <input type="checkbox"/> ON LINE SUBSCRIPTIONS S9446/Dx. Z7189 <input type="checkbox"/> AT HOME FITNESS EQUIPMENT S9446/Dx. Z7189 <input type="checkbox"/> CHILDREN'S FITNESS ACTIVITIES S9451			\$ _____	
PROVIDED BY:					
<b>PLEASE NOTE: DO NOT ENTER ANY ADDITIONAL INFORMATION IN ANY OF THE BOXES ON THIS FORM</b>					

**SECTION 3**

**SIGNATURE AND DATE**

Unsigned forms will be returned

I CERTIFY THAT THE INFORMATION SUBMITTED IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. THE EXPENSES INCURRED WERE FOR MYSELF, SPOUSE, OR QUALIFIED DEPENDENT(S), AND THAT THESE EXPENSES ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE.

**SUBSCRIBER SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals information concerning any fact material thereto, for the purpose of misleading, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of each violation.

**Please Note: COPIES OF ALL BILLS/RECEIPTS MUST BE SUBMITTED WITH THIS FORM IN ORDER FOR YOUR REWARD TO BE CONSIDERED. If you do not have a valid bill or receipt, please contact the provider of service to obtain prior to submitting for your reward reimbursement.**

**NOTE: Please submit one rewards request per reward request form. Separate reward requests need to be submitted for each qualified reward request according to your contract. To be eligible for this reward benefit services must be for one of the qualified expenses listed below.**

**If you have eligibility, benefit or form related questions, please contact customer service using the number listed on the back of your member ID card.**

1) **SECTION 1: INFORMATION REQUIRED FOR REWARD**

COPIES OF ALL BILLS/RECEIPTS FOR QUALIFIED EXPENSES **MUST BE SUBMITTED** WITH THIS FORM IN ORDER FOR YOUR REWARD TO BE CONSIDERED. BALANCE BILL, CANCELLED CHECKS ETC. ARE **NOT** ACCEPTABLE. BILLS MUST **CLEARLY** INDICATE **ALL OF THE FOLLOWING:**

1 – FULL SUBSCRIBER NAME

2 – NAME AND ADDRESS OF INDIVIDUAL OR BUSINESS/ORGANIZATION PROVIDING THE SERVICE

3 – NAME OF MEMBER WHO RECEIVED THE SERVICE

3 – DATE SERVICE WAS RENDERED

4 – CHARGE FOR SERVICE RENDERED

5 – ALL REWARD REQUESTS MUST BE SUBMITTED WITHIN **365 DAYS** AFTER SERVICE WAS PROVIDED IN ORDER TO BE CONSIDERED FOR REWARDS PAYMENT

2) **Section 2**

Subscriber Information (Please enter all information exactly as shown on your ID Card)

**SUBSCRIBER'S LAST NAME:** Last Name of the Subscriber

**SUBSCRIBER'S FIRST NAME:** First Name of the Subscriber

**SUBSCRIBER IDENTIFICATION NUMBER:** Subscriber ID as it appears on your card

**ADDRESS NUMBER AND STREET:** Subscriber home address – please include apartment number if applicable

**CITY:** City in which your home address resides

**STATE:** State in which your home address resides

**ZIP CODE:** Zip Code in which your home address resides

**Patient's Last Name:** Last Name of member who is receiving the service

**First Name:** First name of member who is receiving the service

**Date of Birth:** Date of birth for the member receiving the service in a mm/dd/yyyy format

**Gender:** Gender of member receiving the service

**Patient Relationship to the Subscriber:** Relationship of member to the Subscriber

In this next section: Please complete all sections below for the individual QUALIFIED service rendered. **Individual reward requests need to be submitted for each eligible QUALIFIED service according to your contract. If you do not know your benefit, you can check your benefit by logging into [www.univerahealthcare.com](http://www.univerahealthcare.com) Click on My Account from the main menu and then click on Health and Wellness. Search for "UniveraFit Dollars". Or you can call the phone number listed on the back of your ID Card.**

**DATE of SERVICE:** Date the service was provided

**SERVICE INFORMATION:** Select only ONE provided service per claim form

**REWARD AMOUNT:** Enter in the dollar value for reward you are requesting. This amount must match what it included on your bill/receipt that you are attaching.

**Provided By:** Enter the name of the Individual, Business or Organization providing the service

**PLEASE NOTE: DO NOT ENTER ANY ADDITIONAL INFORMATION IN ANY OF THE BOXES ON THIS FORM**

3) **SECTION 3**

Please verify that all the information above is printed clearly and all of the boxes are appropriately filled out. Once confirmed, please sign and date in the designated section

Mail Completed Form to:

P.O. Box 211256

Eagan, MN 55121-2656