

Non-Participating Health Club Membership Reimbursement Form

Mail form and receipt to:

Palladian Muscular Skeletal Health • P.O. Box 268 • Lancaster, NY 14086

Use this claim form for WellCare *non-participating health club membership* reimbursements only.

Member Name: _____ Member ID: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone: () _____ Date of Birth: _____ / _____ / _____

Receipts must be submitted within 90 days of receipt date and are processed within 30 days of receipt by WellCare. Members can submit up to three reimbursement requests within a 90-day period.

Date Paid

Health Club Name
(Membership dues only)

Amount

1. _____	_____	\$ _____
2. _____	_____	\$ _____
3. _____	_____	\$ _____



By signing this form, I confirm that the request for reimbursement is for non-participating health club membership and is not covered by any other plan or program.

Member's Signature: _____

Date: _____



Remember:

Complete the claim form (page 1).

Also include receipt for non-participating health club membership dues (*you will be reimbursed for **your** membership dues only; no classes or additional services*).

Your receipt must include your name, date paid and have the amount on your receipt **circled** for your membership dues only.

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To get more information or to request additional claim forms, please contact Customer Service at 1-866-238-9898, seven days a week, 8am–2am Eastern. TTY/TDD users can call 1-866-239-6265 or visit www.wellcarepffs.com/member/default.

Health Club

991

DATE 08/13/08

DATE

NAME John Doe

NAME

ADDRESS

CITY STATE ZIP

MEMBERSHIP DESCRIPTION

MONTH

DESCRIPTION

AMOUNT

AUG.

Membership Dues

\$30

AMOUNT

TAX

TOTAL

\$30

TOTAL

