Lumen 192086
Wellness Program
Reimbursement Request

Medical Plan ID Number: ____

Medical Plan Subscriber Name: _______________________________________

Mailing Address: ____

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Expense is for (name): ____

Relationship (check one): Subscriber ________
Spouse/Domestic Partner ________

Weight Watchers (WW) membership: **Code S9449** $______________
Expense is for (month/year, if for multiple months list): ____________________________

Expenses on or after 1/1/2021 are reimbursable up to $55 per month (multiple months may be submitted at one time but not after one year from when the expense was incurred).

All benefit payments will be sent to the subscriber's address on file. A prescription from your physician is required noting a medical condition or illness to receive reimbursement.

Certification and Authorization (this form must be signed and dated below)

I authorize the release of information to UnitedHealthcare about my weight loss program membership. I certify the information provided is complete and correct and that I have not previously submitted for reimbursement of these expenses.

Subscriber/Member
Signature____________________________________Date______________________

Submit this completed form with receipts and prescription to:

UnitedHealthcare
PO Box 30555
Salt Lake City, UT 84130-0555