Lifestyle Education and Tobacco Cessation Request for Reimbursement Form

LARIMER COUNTY

PLAN MEMBER INFORMATION

Plan Member Name:	Email:
Meritain Health Member ID Number:	Phone Number:

CLASS/PROGRAM INFORMATION:

Title of Class/Program:	Class/Program Provider:
Address, City, State, ZIP:	Phone Number:
Where Class/ Program Took Place (if different from above):	
Instructor Name/Credentials:	Exact Date(s) or Date Range of Class/Program:

Please indicate what was addressed in this class or program:

☐ Weight Management	☐ Hypertension/Hypertension Prevention	☐ High Cholesterol/High Cholesterol Prevention	
☐ Stress Management	☐ Diabetes/Diabetes Prevention	☐ Emotional Health	☐ Chronic Disease Management
☐ Nutrition/Health Eating	☐ Tobacco Cessation	☐ Other:	

REIMBURSEMENT REQUEST

Amount must reflect cost after subtracting any monetary rebate/incentive earned by medical plan member. (ie., if the total cost was $100 and the member received $50 cash back for attending 100 percent of the classes, then the Total Reimbursement Requested would equal the remaining $50.)

Total Cost of Class: $_____

Monetary Rebates/Incentives Received: $_____

Total Reimbursement Requested: $_____

Required:

1. Itemized receipt for class/program must be submitted with this form.
2. Class or program overview, syllabus, outline, activity logs, agenda, or other documentation of participation must be submitted with this form.
3. This form, completed in full, and signed by medical plan member.
4. Section below completed and signed by class/program instructor (if program or class is face-to-face, two-way interaction.)

SECTION TO BE COMPLETED BY INSTRUCTOR (IF APPLICABLE):

- I verify that the class/program information listed on this form is correct.
- Did the participant receive any discounts, monetary rebates or reimbursements?

☐ Yes, please list amount $_____ ☐ No.

- If the program involved more than one class, please check to verify:

☐ Participant attended at least 75 percent of the program. ☐ Participant completed an evaluation of assessment.

Instructor Name (Please Print)_____ Instructor Signature and Date:_____

MEMBER ATTESTATION

I verify the reimbursement I am requesting is for education only and is not for anything listed in the inclusion list. (ie., physical activity or fitness classes, gym memberships, physical activity event registration fees, safety classes, personal training, counseling, coaching, food, supplements, smoking cessation products, etc.)

Plan Member Signature: _____ Date: _____

REIMBURSEMENT SUBMITTAL INFORMATION:

Complete and submit this completed form, with required attachments to Meritain Health. For questions call: **1.800.925.2272** Fax: **1.736.862.5057**

To submit online: log in to your Meritain Health member portal at **www.meritain.com** or

Mail to: Meritain Health
P.O. Box 853921
Richardson, TX 75085-3921

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