**ZOLL Medical Corporation – 1678972**

Wellness Program Reimbursement Request-Fitness

Member ID Number: _____

Employee Name: _____

Address: _____

_____

Member Name: _____

Relationship (check one): Subscriber _____
Dependent _____

Health Club Membership CPT Code 99075 $ _____

All benefit payments will be sent to the subscriber's address on file.

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

I authorize the release of information to UnitedHealthcare about my health club and/or 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 to: **UnitedHealthcare**
**PO Box 740800**
**Atlanta, GA. 30374**

**FOR INTERNAL USE ONLY:**

- Members may receive up to $150 reimbursement per family per calendar year for fitness (gym) membership
- Use place of service HM, CPT code 99075, and diagnosis code Z00.00.
- Use override code 09
- Documentation is required on the BCI Screen to include amount paid and member(s) involved.
- Club to determine date(s) of service, NOT THE DATECLAIMS TRANSMITTAL IS SIGNED/SUBMITTED
    - Provider TAXID # is not available