UPMC HealthyU

UPMC HEALTH PLAN

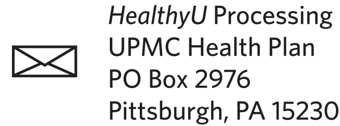
Incentive Submission Form

Use this form to provide documentation of completion of qualifying healthy activities for *HealthyU* incentive rewards. Incentives that can be processed using this form include:

- Dental exams
- Vision exams
- Flu shots that were not paid for as a medical claim

Please complete this form in its entirety. Incomplete forms will be returned to the submitter.

Mail or fax this completed form and documentation to:



HealthyU Processing
UPMC Health Plan
PO Box 2976
Pittsburgh, PA 15230

Fax: 412-454-2796

Please allow two weeks for processing.

A. Subscriber Information

This section refers to the policyholder.

First Name: ____________________ Last Name: ____________________

Member ID #: ____________________ Contact Phone: ____________________

E-Mail Address: ____________________

Street Address: ____________________

City: ____________________ State: __________ ZIP Code: __________

B. Activity Details

Instructions:

1. Select Activity Type: one type per block, maximum of three activities on each copy of this form.
2. Enter date the service was received. Service date must be during *HealthyU* coverage and submitted within one year of service.
3. Name and UPMC member ID # for member who received service (ID number is listed on the individual's member ID card).
4. Documentation must include description of service, name of provider, date service was provided, and name of member receiving service. A copy of the documentation must be included with this form.

1. Activity Type		2. Service Date/Provider		3. Member Information		4. Documentation
1	Dental exam Vision exam Flu shot	Date: Provider Name:		Name: UPMC Member ID:		EOB Bill/receipt from provider
2	Dental exam Vision exam Flu shot	Date: Provider Name:		Name: UPMC Member ID:		EOB Bill/receipt from provider
3	Dental exam Vision exam Flu shot	Date: Provider Name:		Name: UPMC Member ID:		EOB Bill/receipt from provider

C. Authorization

By signing below, I am attesting that the information documented on this form is accurate to the best of my knowledge. I understand that submission of this form is not a guarantee of incentive reward. All incentives will be processed at the time of receipt and according to rules and account balances at the time of processing.

____________________ ____________________ __________

Printed Member Name | Member Signature | Date

This is not a reimbursement form. If you have a claim that you wish to submit for payment, log in to *My*Health OnLine at www.upmchealthplan.com and click on Self-Service Tools to download a claim form.

Questions? We can help. Call UPMC Health Plan Member Services at the number located on the back of your member ID card.

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