

Milwaukee County Wellness Program Claim Form for Milwaukee County's Managed Care Plan B



1717 W. Broadway—P.O. Box 8190
Madison, WI 53708-8190

Request for reimbursement, accompanied by a receipt verifying payment must be submitted within one calendar year from date of payment.

Benefit limited to \$100.00 per member, per calendar year.

For prompt claim service, complete form, attach receipts, and mail to:

**WPS
P.O. Box 8190
Madison, WI 53708-8190**

Participant's Name

Member's Daytime Phone Number

Birthdate

Relationship to Insured
 Self Dependent

Group Number
157568

Member Number

Insured's Name & Address

Do you or your spouse have other health insurance coverage for any of these expenses?

Name

No Yes If yes, please provide the following information:

Address

Other Insurance Name

City

Other Insurance Address

State

Zip

Other Policy Number

Please also attach an Explanation of Benefits from Primary Carrier

Health Club Memberships

Dates of Membership	Description of Membership	Charges	Name, Address, & Phone of Facility
from ____/____ to ____/____	<input type="checkbox"/> Single <input type="checkbox"/> Family Membership		
from ____/____ to ____/____	<input type="checkbox"/> Single <input type="checkbox"/> Family Membership		

Other Health Education Classes

Dates of Class	Description of Class	Charges	Name, Address, & Phone of Facility
from ____/____ to ____/____			
from ____/____ to ____/____			

I authorize release of any information relating to this claim. *Signature of Insured*

Date