

TeamstersCare 2010 Healthy Incentive Program (HIP) Claim Form

Member's Name: _____ Member's Social Security No: _____

Address: _____ Phone Number: _____

Member and/or Spouse may complete HIP activities. Indicate below the HIP activity completed by Member and/or Spouse; check all that apply; you may complete each activity only once. ***Documented proof of completion required for all activities.*** Combined maximum amount that can be earned toward reimbursement of eligible healthcare expenses in 2010 is \$300 per family.

<u>Earned Dollar Amount</u>	<u>HIP Activity</u>	<u>Person Completing Activity</u>	
\$200	Lose 15% of your body weight	<input type="checkbox"/> Member	<input type="checkbox"/> Spouse
	Complete a road race/walk, 5 miles or longer	<input type="checkbox"/> Member	<input type="checkbox"/> Spouse
	Complete a bike race or bike-a-thon, 50 miles or longer	<input type="checkbox"/> Member	<input type="checkbox"/> Spouse
\$150	Screening mammogram	<input type="checkbox"/> Member	<input type="checkbox"/> Spouse
	Prostate cancer screening (if not part of routine physical)	<input type="checkbox"/> Member	<input type="checkbox"/> Spouse
	Colonoscopy	<input type="checkbox"/> Member	<input type="checkbox"/> Spouse
	Complete a smoking cessation program	<input type="checkbox"/> Member	<input type="checkbox"/> Spouse
	Enroll in a disease management program	<input type="checkbox"/> Member	<input type="checkbox"/> Spouse
\$100	Lose 10% of your body weight	<input type="checkbox"/> Member	<input type="checkbox"/> Spouse
	Complete a road race/walk, 3 miles or longer	<input type="checkbox"/> Member	<input type="checkbox"/> Spouse
	Complete a bike race or bike-a-thon, less than 50 miles	<input type="checkbox"/> Member	<input type="checkbox"/> Spouse
	Have a routine physical exam	<input type="checkbox"/> Member	<input type="checkbox"/> Spouse
	Have a skin cancer screening	<input type="checkbox"/> Member	<input type="checkbox"/> Spouse
\$50	Have a preventive dental exam and dental cleaning	<input type="checkbox"/> Member	<input type="checkbox"/> Spouse
	Have a TeamstersCare audiology hearing screening	<input type="checkbox"/> Member	<input type="checkbox"/> Spouse
	Have a face-to-face meeting with TeamstersCare Mental Health's Employee Assistance Program/EAP	<input type="checkbox"/> Member	<input type="checkbox"/> Spouse
	Attend 4 or more RAFT meetings (must be verified by the Raft Program Director)	<input type="checkbox"/> Member	<input type="checkbox"/> Spouse
	Make appointment and meet with a TeamstersCare Pharmacist for a medication review	<input type="checkbox"/> Member	<input type="checkbox"/> Spouse
	Complete a yoga/meditation program	<input type="checkbox"/> Member	<input type="checkbox"/> Spouse

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Member's Name: _____ Member's Social Security Number: _____

Expenses for Which You Request Reimbursement

Name of Person Receiving Service/Supplies	Relationship to Member	Provider of Service or Supplies	Date of Service	Type of Service or Supplies	Amount to Be Reimbursed

CERTIFICATION

To the best of my knowledge, the above information is accurate.

- I certify that HIP activities have been performed during 2010. TeamstersCare reserves the right to verify information.
- I am requesting payment only for eligible expenses incurred during the period for which I am eligible, and only for those expenses not eligible for payment under any other benefit plan. I will not deduct these expenses on my individual federal tax return.

Member's Signature

Date

MAIL HIP CLAIM FORM TO: TeamstersCare Member Services 16 Sever Street, Charlestown, MA 02129-1305

Instructions for Completing a HIP Claim Form

1. Please print. Complete **all** sections on the reverse side of this form. The **member** must **sign** and **date** at the bottom.
2. All HIP activities checked must be completed in 2010 (**from January 1, 2010 through December 31, 2010**).
3. Member and/or spouse can earn up to a combined maximum of \$300 per family for reimbursement of eligible healthcare expenses. See the list of Healthy Incentive Program activity descriptions and dollar amounts each activity earns.

Remember: HIP activities must be completed by the member and/or spouse; however, reimbursement can be for eligible expenses of any covered family member.

4. First submit all expenses to any other benefit plan for which the patient is eligible. You may then apply for reimbursement of the expenses not covered in part or in full. You may not request reimbursement until you have received the service, regardless of when you pay for it.
5. In order to receive HIP reimbursement, attach legible **copies** of your out-of-pocket bills or receipts (**cancelled checks, charge card or cash receipts are not valid**) for each of the expenses you list. You should accumulate your bills and then submit as a single claim.
6. **TeamstersCare will issue HIP checks to members only, six times per year** (January 31, March 31, May 31, July 31, September 30 and November 30).
7. The attached itemized bills must include:
 - Name of person receiving the service/supplies
 - Name of person/organization providing the service/supplies

- Date the service/supplies were provided
 - Description of service/supplies (if prescription drugs, receipt should include prescription number, name of medication, date of purchase, and name of prescribing physician)
 - Total charge for the service/supplies (amount for which you are requesting reimbursement)
 - If expenses were first submitted to another benefit plan, attach the Explanation of Benefits (EOB form) from the plan that shows the amount paid or reimbursed
 - Keep your **original** bills and proofs of payment for your records
8. Send the completed **HIP Claim Form** and copies of your paid bills to **TeamstersCare Member Services, 16 Sever Street, Charlestown, MA 02129-1305**. You may want to keep a copy of the form for your records.
 9. According to IRS regulations, any unused year-end balance in your HIP account may not be carried over to the next Plan year. Claims for the previous year must be submitted by March 31.

**MAIL HIP CLAIM FORM TO:
TeamstersCare Member Services
16 Sever Street, Charlestown, MA 02129-1305**