

Statement of Claim for Smoking Cessation Program Reimbursement

UNITEDhealthcare®
Policy # 183644

To Be Completed by Employee

1. Employee's Name		2a. Date of Birth Mo. Day Year			2b. Social Security Number					3. <input type="checkbox"/> Male <input type="checkbox"/> Female		4. <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA <input type="checkbox"/> Surviving Spouse		
5a. Home Address (Give Exact Postal Address Including Zip Code)										5b. Telephone No. (Home)				
6. Patient's Name (If for dependent, complete)		7. Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child		8. Date of Birth Mo. Day Year			9. <input type="checkbox"/> Male <input type="checkbox"/> Female			10. <input type="checkbox"/> Single <input type="checkbox"/> Married				
							11. Social Security Number			12. If Full Time Student School _____ City/State _____ Phone _____				
Pfizer will reimburse its employees and eligible dependents for participation in the following Smoking Cessation Programs, which include but are not limited to: Smokers, Smoke Stoppers, nicotine patches, nicotine gum, acupuncture and hypnosis. Employees and their eligible dependents will be reimbursed for no more than two programs.														
13. When did this Program Begin? _____ End? _____ Is this the <input type="checkbox"/> First or <input type="checkbox"/> Second Program for which you are seeking reimbursement?														
14. Is the person for whom reimbursement is being sought eligible for reimbursement through any other Smoking Cessation Program? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Program _____ or organization involved with the Program _____														
										Amount of reimbursement requested \$ _____				
15. I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon or pharmacist to release any information requested with respect to this claim. I certify that the information furnished by me in support of this claim is true and correct. I know that it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.														
Date _____		Signature of employee _____ Also Signature of dependent _____												
Only if patient and not a minor.														

Complete This Section Only if You Wish the Benefits to be Paid Directly to the Provider		
Authorization to Pay Benefits: I hereby authorize payment directly to:		
PRINT _____ (Hospital)	(Physician or Surgeon)	(Other)
Provider's Address _____		
City _____	State _____	Zip Code _____
Provider's Phone Number _____		
I understand I am financially responsible for the expenses not covered under the Pfizer Smoking Cessation Program.		
Date _____	Signature _____	
Authorizations will be honored only if a valid Tax identification or Social Security number for the provider is shown on the billing submitted.		

Attach Bill(s) or Receipt(s) and Mail Completed Form To: **United HealthCare Insurance Company**
Group Claims Office
P.O. Box 740800
Atlanta, GA 30374-0800

If you have any questions, contact United HealthCare at 1-800-638-8010.