Risk Management

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Clark County Self-Funded Benefit Plan
Wellness Benefit Designation Form

Member Name: ______________________________

Patient Name: ______________________________

Member ID Number: ______________________________

The Plan provides a wellness benefit up to $200.00 per calendar year for the following routine services for each covered employee/retiree, covered spouse and covered dependent. This benefit may not be accumulated from year to year if the benefit is not used. An itemized statement must be submitted in order to receive this benefit. For the submission of medications for smoking cessation or weight loss; the medication must be recognized and approved by the FDA for the treatment of smoking cessation or weight loss; receipts must be from a pharmacy and include the name of the drug, patient's name, date dispensed, and amount of purchase. This benefit does NOT cover deductibles, co-payments, co-insurance or any amount over reasonable and customary applied by the plan.

(1) Eyeglasses or contact lenses (not covered by vision plan)
a copy of the EyeMed denial form and/or explanation of benefit's (EOB) **MUST be attached**
Bill/receipt from Eye Provider is also needed when submitting for eye care
(2) Vitamin B injections administered and supplied by a medical provider
(3) Programs to stop smoking as approved or prescribed by a physician
(4) Weight loss program as approved or prescribed by a physician
(5) Check-ups (including routine physical examination, lab tests & x-rays) or immunizations not covered under the Preventive and Wellness Services as specified by the Affordable Care Act.
(6) Wig (Cranial Prosthesis) due to hair loss caused by Chemotherapy Treatments

Wellness claims filed more than 12-months after the date of service will not be eligible

I hereby certify that I would like the following expenses applied to my wellness benefit.

Wellness Service Description: ______________________________

Amount to be applied to Wellness Benefit: ______________________________

Date of Service: ______________________________

Provider of Service: ______________________________

Claim Number (if known): ______________________________

Pay the above amount to: Member ☐ Provider ☐
(If left blank, the amount will default and be paid to the provider of service)

______________________________ ______________________
Signature Date

Please mail your completed form and back up documentation to:
UMR - Clark County Self-Funded Plan
PO Box 30541
Salt Lake City, UT 84130-0541 or email to: umr_clarkwellness@umr.com or fax 702-455-3084

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