USAble Life

WELLNESS BENEFIT | REQUEST FORM

THANKS FOR BEING OUR CUSTOMER!

Complete this form to request your calendar year Wellness Benefit.

Call us with questions at 800-370-5856, Monday through Friday, 8:00 A.M. to 5:00 P.M. CST.

WHERE TO SUBMIT YOUR REQUEST:
Attention: Claims Department
Mail: PO Box 1650 | Little Rock | AR | 72203
Email: claims@usablelife.com
Fax: 501-235-8400

POLICYHOLDER INFORMATION

WHO THE INSURANCE POLICY IS LISTED UNDER

POLICYHOLDER NAME (FIRST, LAST) SOCIAL SECURITY NUMBER POLICY NUMBER BIRTH DATE

EMPLOYER NAME POLICYHOLDER PHONE POLICYHOLDER EMAIL ADDRESS

HOME ADDRESS 1 ADDRESS 2 CITY STATE ZIP

PATIENT INFORMATION

WHO THE SERVICE/TEST WAS FOR

PATIENT NAME (FIRST, LAST) SOCIAL SECURITY NUMBER BIRTH DATE SERVICE/TEST DATE

PATIENT RELATIONSHIP TO POLICYHOLDER: **SELF** **SPOUSE** **DEPENDENT**

SERVICE/TEST PERFORMED | SELECT THE SERVICE OR TEST PERFORMED.

PLEASE NOTE: YOUR POLICY MAY NOT COVER ALL OF THE TESTS AND SERVICES LISTED BELOW. FOR AN ACCURATE LIST OF TESTS AND SERVICES COVERED BY YOUR POLICY, PLEASE REFERENCE YOUR CERTIFICATE OF INSURANCE.

Routine Exam/Physical	Ultrasounds	Biopsy
Vision Exam	EKG	Cancer Prevention *(Vaccine/Immunizations)*
Dental X-Ray	Thermography	CEA *(blood test for colon cancer)*
Chest X-Ray	Breast MRI	PSA *(blood test for prostate cancer)*
Flexible Sigmoidoscopy	Mammogram*	CA 15-3 *(blood test for breast cancer)*
Hemocult Stool Specimen	Pap Smear-ThinPrep*	CA 125 *(blood test for ovarian cancer)*
Colonoscopy		

***FOR PA RESIDENTS ONLY** | If applicable, enter the actual cost of service/test below.

MAMMOGRAM **$** PAP SMEAR-THIN PREP **$**

PROVIDER INFORMATION

WHO PERFORMED THE SERVICE/TEST

NAME OF MEDICAL FACILITY PEFORMING PHYSICIAN NAME (FIRST, LAST)

MEDICAL FACILITY ADDRESS 1 ADDRESS 2 CITY STATE ZIP

REQUESTOR SIGNATURE

SIGN AND DATE YOUR REQUEST

I understand approved benefits will be sent to the home address listed above.

REQUESTOR RELATIONSHIP TO POLICYHOLDER: **SELF** **SPOUSE** **DEPENDENT**

PRINT NAME (FIRST, LAST) SIGNATURE SIGNATURE DATE

FRAUD WARNING: EXCEPT AS NOTED IN THE SEPARATE FRAUD NOTICE, ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.