



HealthDollarssm/TriVantage Reimbursement Form

- Please use this form for reimbursement for TriVantage Active Lifestyles or TriVantage Family Focus benefits, or for reimbursement for your \$50 HealthDollarssm benefit.
- The HealthDollarssm benefit is available to subscribers of Preferred Care employer self-funded plans; Commercial plan members (Basix, CareFund, Community, Comprehensive, Opportunity, TriVantage, and USdirect plans), as well as Preferred Care Gold (Medicare Advantage), and Preferred Care GoldAnywhere (Medicare Advantage PPO). Members enrolled in Preferred Care's Personal Plan, a Preferred Care health plan through Xerox, or Healthy NY are not eligible.
- Reimbursement forms must be received no later than one year after the date you paid for the service.
- Please PRINT. For more information about completing the form, see the reverse side.

Member Information: (for the specific member using this benefit)

Health Plan ID #:																			
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Member's Last Name	First Name	Middle Initial	Date of Birth (MM/DD/YYYY)
Address		City/State/Zip Code	Phone Number

Please check all that apply:

- HealthDollarssm (\$50 annual maximum)
- Health Club membership (\$300 annual maximum, TriVantage Active Lifestyles subscriber)
- Driver's Education, Swimming or Lifeguard Classes (\$300 annual maximum, TriVantage Family Focus subscriber)

Name, address and phone number of service provider	Amount Paid	Date of Payment
A.C.T. ~ For the Children - c/o Children's Institute, Inc. 274 North Goodman Street, Suite D-03 Rochester, NY 14607 Program Administrator: (585) 428-1930	\$ 75.00	

Total number of receipts attached: _____

Total paid: \$ 75.00

Certification and Authorization: (this form must be signed below)

I authorize the release of any information to Preferred Care about my HealthDollars/TriVantage benefit utilization. I certify that the information provided in support of this submission is complete and accurate and that I have not previously submitted for or been reimbursed for these same services.

Subscriber's signature _____

Date _____

Any person who knowingly files a reimbursement request containing any misrepresentation or any false, incomplete or misleading information is guilty of a criminal act punishable under law and may be subject to civil penalties.

Return to: Preferred Care, HealthDollars & TriVantage, P.O. Box 22920, Rochester, New York 14692-2920 (see reverse side for guidelines on completing this form)

For Office Use Only:

Provider #	HHHHHH					Loc/POS	CPT/HCPCS	Diagnosis Code	Charges
From		Date of Payment			To				
MM	DD	YY	MM	DD	YY				
						99	S9446	V689	
						99	S9970	V689	
						99	S9986	V689	
						99	99199	V689	
Total:									

How to Submit Your HealthDollarssm or TriVantage Reimbursement Request

In order to process your request promptly, please refer to the following guidelines to ensure that all necessary information is included.

1. This form may be used for the following two types of reimbursement requests ONLY:
 - TriVantage health plan benefits ("Active Lifestyles" or "Family Focus" plans)
 - HealthDollarssm benefit. This benefit is provided to each subscriber (household). For example, a family of four would receive one \$50 HealthDollars annual reimbursement.
2. All reimbursement forms must be received by Preferred Care no later than one year after the date you paid for the service.
3. The HealthDollars benefit applies to the year in which the service is paid. For example, if a service was provided in December 2006, but you paid for it in January 2007, it will apply to your 2007 HealthDollars benefit. You must have been a Preferred Care member at the time of payment.
4. Attach the pre-printed, paid original receipt showing the type of service:
 - You must pay for the service before submitting a request for reimbursement.
 - For each item you are requesting, you must attach a copy of itemized bills, statements or receipts preprinted or stamped with the service provider's name and address.
 - Debit/credit card statements, cancelled checks and balance forward/prior balance statements are not acceptable.
 - The documentation from the service provider must include the following information:
 - The name of the provider;
 - The type of service provided;
 - The date the service was rendered (start date);
 - Your out-of pocket cost for the service, including date(s) of all payment(s); and
 - The name of the person(s) receiving the service.
 - Please note: reimbursement requests that are not submitted according to these guidelines will be returned for you to correct and re-submit.
5. Preferred Care reserves the right to refuse reimbursement if the service provider does not meet benefit and quality standards as determined by Preferred Care.
6. Merchandise, such as attire, fitness equipment, fitness videos and publications, golf clubs, bicycles, and entry fees do not qualify for reimbursement.

Country club fitness facilities and swim lessons at country clubs qualify for reimbursement only if there is an additional charge for the fitness facility/swim lessons that is billed separately from the membership fee and/or dues.
7. TriVantage "Active Lifestyles" subscribers will be reimbursed for health and fitness club memberships only. Individual exercise programs and personal trainer services do not qualify.
8. Sign this form and return it to: Preferred Care
HealthDollars & TriVantage
P.O. Box 22920
Rochester, New York 14692-2920
9. Please allow 4-6 weeks for reimbursement (as long as your request is complete and accurate).
10. Please visit our Web site at www.preferredcare.org for more information about HealthDollarssm and TriVantage health plan benefits.

Preferred Care is dedicated to prompt and accurate reimbursements to our health plan participants. By following these instructions and filling out the reimbursement form completely, you will help us process your request in a satisfactory manner. Thank you!