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. ☐ Male ☐ Female
4. ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Active ☐ Retired ☐ COBRA ☐ 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 — ☐ Spouse ☐ Child
8. Date of Birth — Mo. | Day | Year
9. ☐ Male ☐ Female
10. ☐ Single ☐ 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: Smokenders, 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 ☐ First or ☐ 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?

☐ Yes ☐ 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.

3.PF-H-421L.100

MB3229.GRN(07103)