LIFESTYLE EDUCATION & TOBACCO CESSATION
REQUEST FOR REIMBURSEMENT FORM

PLAN MEMBER INFORMATION

Plan Member Name: ___________________________ Email: ___________________________
UMR Member ID Number: ______________________ Phone Number: ____________________

CLASS/PROGRAM INFORMATION:

Title of Class/Program: ________________________ Class/Program Provider: __________________
Address, City, State, Zip: ______________________ Phone: _____________________________
Where Class/Program Took Place (if different from above): ________________________________
Instructor Name/Credentials: ___________________ Exact Date(s) or Date Range of Class/Program: __________

Please indicate what was addressed in this class or program:

☐ Weight Management ☐ Hypertension/Hypertension Prevention ☐ High Cholesterol/High Cholesterol Prevention
☐ Stress Management ☐ Diabetes/Diabetes Prevention ☐ Emotional Health ☐ Chronic Disease Management
☐ Nutrition/Health Eating ☐ Tobacco Cessation ☐ Other: ________________________________

REIMBURSEMENT REQUEST: Amount must reflect cost after subtracting any monetary rebate/incentive earned by Medical Plan Member. (i.e., if total cost was $100 and Member received $50 cash back for attending 100% of the classes, then Total Reimbursement Requested would equal the remaining $50.)

Total Cost of Class: $ ______________
Monetary Rebates/Incentives Received: $ ______________
Total Reimbursement Requested: $ ______________

REQUIRED: 1. Itemized receipt for class/program must be submitted with this form.
2. Class or program overview, syllabus, outline, activity logs, agenda, or other documentation of participation must be submitted with this form.
3. This form, completed in full, and signed by Medical Plan Member.
4. Section below completed and signed by Class/Program Instructor (if program or class is face-to-face, two-way interaction.)

SECTION TO BE COMPLETED BY INSTRUCTOR (IF APPLICABLE):

• I verify that the class/program information listed on this form is correct.
• Did the participant receive any discounts, monetary rebates or reimbursements?
  ☐ Yes, please list amount. $ ______________  ☐ No.
• If the program involved more than one class, please check to verify:
  ☐ Participant attended at least 75% of the program.  ☐ Participant completed an evaluation of assessment.
Instructor Name (Please Print): ________________________ Instructor Signature and Date: __________________________

MEMBER ATTESTATION

I verify the reimbursement I am requesting is for education only and is not for anything listed in the inclusion list (i.e., physical activity or fitness classes, gym memberships, physical activity event registration fees, safety classes, personal training, counseling, coaching, food, supplements, smoking cessation products, etc.)

Plan Member Signature: ___________________________ Date: __________________________

REIMBURSEMENT SUBMITTAL INFORMATION: Complete and submit this completed form, with required attachments to UMR. Allow 10-14 business days for processing. For questions, call: 1-800-826-9781

EMAIL LCReimbursementClaim@umr.com
FAX (Attn: Larimer County Team) 866-859-1112
US MAIL (Attn: Larimer County Team) 20021 120th Avenue NE, Suite 200, Bothell, WA 98011