2018-2019 Physical Exam Reward

The Annual Physical Reward program pays you and your eligible dependents for getting an annual physical exam from a primary care physician. Annual physical exams carry a $0 co-payment so this is truly a reward!

Read the Guidelines:

- Enrollees and dependents are eligible annually for the reward. The enrollee must be/have been an active NY44 Trust participant at the time of the physical.
- Single plan participants can earn $100.
- Family plan participants can submit for a maximum of two Physical Exam rewards per plan year. ($100 each; $200 plan year maximum)
- Examples are Adult Annual Physical Exam or Child's Annual Well/Physical Exam.
- OB/GYN annual visits are **NOT** eligible. DOT, camp or work physicals are **NOT** eligible.
- Exam must be completed between July 1, 2018 - June 30, 2019 to be eligible.
- **SUPERBILLS ARE NOT ACCEPTED DOCUMENTATION**.
- Claim will be denied unless all of the required documentation is included.

Required Documentation

☐ This form

☐ Physician script or medical facility letterhead that documents:

1. Patient's name
2. Date of annual physical or well child exam (between July 1, 2018- June 30, 2019)
3. Language indicating the visit was for wellness, child's preventive exam, adult preventive, annual physical exam, etc. **OB/GYN annual visits are not eligible. DOT, camp and/or work physical exams are not eligible.**
4. Name of Physician

PLEASE NOTE: The results of the exam SHOULD NOT be reported to the Trust

Please submit one form per physical. Submission Deadline: This form and proper physician documentation dated between July 1, 2018 and June 30, 2019 must be submitted by July 15, 2019. **No Exceptions**. Claims will take 6-8 weeks to process. Please refrain from inquiring on status until the full 8 weeks have passed. Payment is made directly to the primary enrollee (no third party payments).

Please Complete the Information Below:

Check one: ☐ Single Health Coverage ☐ Family Health Coverage

Employer (School District/ School Name): _____

Primary Enrollee Last Name: _____ Primary Enrollee First Name: _____

Home Address/City/State/Zip: _____

Phone: _____ Enrollee Email: _____

Mail /Fax Form and Documentation: **Emailed or Hand delivered submissions will not be accepted.**

Wellness Annual Physical Reward Payment
Attn: Jeni Kapalczynski
NY44 Health Benefits Plan Trust, Erie 1 BOCES
355 Harlem Road, West Seneca, NY 14224

FAX -- 716-821-7439

Guidelines/Forms online at www.ny44.e1b.org. Questions, 716-821-7161 *Rev.4/18/2018*