



Wellness

3786 Broadway
Cheektowaga, NY 14227
(716) 601-7980

Labor-Management Healthcare Fund (LMHF) is the administrator of health, prescription, and dental coverage.

It is our goal to help ensure your overall satisfaction with our program, plans of benefits offered, performance of insurance carriers, and all customer service conduct.

Employee Verification LMHF Part I Wellness Incentive Program Page 1 of 2

Instructions:

Please complete the information below, have your physician complete and sign the reverse side and return to the Labor-Management Healthcare Fund office in the enclosed self-addressed envelope. **Faxes Not Accepted.**

DO NOT return documents to your employer.

I hereby confirm that I have completed Part I (Annual Physical) resulting in eligibility for receipt of a Health Related Expenses (debit) card. I understand that this document will be confirmed by the LMHF prior to receiving my card. My HRA card will be provided to me by the LMHF office via U.S. mail within 3 to 4 weeks. You will be notified directly if the LMHF office is unable to confirm your documentation.

Applicant's Signature: _____

Printed Name: _____

Date Signed: _____

Date of Birth: _____

BCBS Member (ID) Number: _____

Prefix (Ex. 01, 02) ID Number

BCBS Group Number*: _____

Home Address: _____

House Number & Street Apartment #

City & State Zip Code

Phone Number with Area Code: _____

*Your BCBS Prefix, Member ID and Group numbers appear on your BCBS identification card.

Subscriber's Information

Union Affiliation: _____

Employer Name: _____

Department: _____

Reverse Side (Page 2) Must be Completed by Physician



Annual Physical Verification
For Part I - LMHF Wellness Incentive Program
Page 2 of 2

I hereby confirm that I am the Physician for _____,
(Patient Name – please print)

BlueCross BlueShield Member Identification Number _____.

This patient presented on _____, _____, 20 and received their
(Month) (Day) (Year)

Annual Physical Examination.

Physician Signature: _____

Physician's Printed Name: _____

Date Signed: _____

Original Signatures are Required. Faxed Copies Not Accepted