LMHF ®
Wellness
www.LMHF.net
(716) 601-7980

Labor-Management Healthcare Fund
90 Anderson Road
Cheektowaga, NY 14225

Employee Verification
LMHF Part I Wellness Incentive Program

Instructions:

Please complete the information below, have your physician complete and sign the reverse side and return to the Labor-Management Healthcare Fund office.

This form must be submitted no later than February 15 for the prior year's participation.

There are NO exceptions.

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-Reimbursement Arrangement (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. Please notify the LMHF office if you do not receive confirmation that LMHF received your submission within two weeks of the time you submitted it.

Applicant's Signature: _____

Printed Name: _____

Date Signed: _____

Date of Birth: _____

Highmark/BCBS Member ID Number: _____
ID Number

Highmark/BCBS Group Number*: _____

Home Address: _____
House Number & Street *Apartment #*

_____
City & State *Zip Code*

Phone Number with Area Code: _____

*Your Highmark/BCBS, Member ID and Group numbers, appear on your Highmark/BCBS Insurance card

Subscriber's Information

Union Affiliation: _____

Employer Name: _____

Department: _____

Reverse Side (Page 2) Must be Completed by Physician

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Annual Physical Verification
For Part I - LMHF Wellness Incentive Program

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

Highmark/BCBS Member Identification Number _____.

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

Annual Physical Examination.

Physician Signature: _____

Physician's Printed Name: _____

Date Signed: _____

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