LMHF™

Wellness

www.LMHF.net

(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.

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 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. Please notify the LMHF office if you do not receive confirmation within two weeks that the LMHF office received your Part I submission.

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

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Wellness

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: _____

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

Reverse Side (Page 1) Must be Completed by Employee