

WEIGHT MANAGEMENT AND SMOKING CESSATION CLAIM FORM

Patient's first name: _____ Patient's last name: _____	Patient's date of birth: Month Day Year <table border="1" style="width:100%; height: 20px; margin-top: 5px;"> <tr> <td style="width:33%;"></td> <td style="width:33%;"></td> <td style="width:33%;"></td> </tr> </table> Relationship to Member: Self Spouse Child Other <table border="1" style="width:100%; height: 20px; margin-top: 5px;"> <tr> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> </tr> </table>								Member's SSN or NGS Unique ID#: _____
Member's first name: _____ Member's last name: _____	Member's Address: _____ _____								

Reimbursement :

- Payment of program costs will not be paid until the service has been provided.

Choose one program and complete program information box:

Reimbursement upon program completion *(Please do not submit receipt for reimbursement until program is completed)*

Total Paid: \$ _____ Period Covered: _____

Weekly Payment Program

Registration Fee: \$ _____

Meeting Attendance Record

Date	Coordinator/Provider verifying attendance (print and sign name)	Weekly Paid Amount (if applicable)

I certify that to the best of my knowledge the expenses listed above have been incurred by me and/or my eligible dependent and will not be reimbursed by any other health benefit plan. I certify this is an eligible expense, as defined in the Summary Plan Description.

Any person who knowingly files a statement of claim containing any false, incomplete or misleading information with intent to defraud or deceive may be guilty of a criminal act punishable under law.

Employee Signature _____ **Date** _____

PLEASE NOTE: INCOMPLETE CLAIM SUBMISSION MAY RESULT IN A DELAY IN CLAIM PROCESSING AND MAY CAUSE YOUR CLAIM TO BE RETURNED TO YOU. PLEASE BE SURE TO INCLUDE ALL NECESSARY INFORMATION.

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1. Reimbursements are made based on the date of service, as services are rendered or after completion of the program. For example, you begin a program November 1, 2005 and make full payment for the program of \$300. (\$50 per month for six months) At the end of January you may submit the charge(s) incurred for January (\$50) or you may wait until the completion of the program and submit for charges incurred January through April (\$200).
2. When submitting a request for reimbursement remember that the analyst needs an itemized statement or bill showing a breakdown of the charges along with the date the services were incurred. A receipt that only shows a total charge does not provide the information needed to reimburse you.
3. Always complete the Weight Management / Smoking Cessation Claim Form. Do not leave any sections blank that should be filled in. The List of Covered Expenses outlined in the medical plan Summary Plan Description section is particularly important since you are providing the analyst with the information he/she needs to process your claim. You must sign and date the form in order for your claim to be processed.
4. If an expense is covered under any other group medical, an "Explanation of Benefits" (EOB) form from each of the coverage's must be attached to the completed claim form in order for your claim to be processed.
5. Remember that eligible expenses are those incurred in the plan year in which you are participating.

Reimbursement of expenses will be made to the participant upon submission of charge and proof of payment. Payment will only be made to the provider if they submit a claim on your behalf.

Please mail this claim form along with any applicable receipts to:

*NGS American
PO Box 7676
St. Clair Shores, MI 48080*