# Wellness Dollar Reimbursement Form

MERITAIN HEALTH
An Aetna Company

**Complete and send to:**

**Fax: 985-850-3261 or hrclaims@htdiocese.org**

| PLEASE PRINT: | |
|---|---|
| INSURED/EMPLOYEE NAME: | PATIENT NAME: |
| ID NUMBER (SSN/PARTICIPANT NUMBER): | DATE OF BIRTH: |
| INSURED/PATIENT ADDRESS: | |
| PHONE NUMBER (INCLUDING AREA CODE: | |

**WELLNESS REIMBURSEMENT INFORMATION:**

| Date of Service (Month, Day, Year) | Service Type | Total Charges | Amount Paid | Total Due |
|---|---|---|---|---|
| | | | | |
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| PLEASE MAKE CHECKS PAYABLE TO (CIRCLE): |
|---|
| INSURED |

**I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.**

**Insured/Patient Signature:**_______________________________________ **Date:**___________________________