Healthsense Wellness Claim Form

For Prompt Claim Service - Complete form, attach receipts and mail or fax to:

WPS Health Insurance
Attn: Tim Ottosen • P.O. Box 8190 • Madison, WI 53708 • Fax: 608-223-5861

PARTICIPANT'S NAME:		PARTICIPANT'S PHONE NUMBER: (H): (W):	BEST TIME TO CALL WORK:
BIRTHDATE:	RELATIONSHIP TO INSURED: ❑ SELF ❑ SPOUSE	GROUP-DIVISION NUMBER:	CUSTOMER NUMBER:
INSURED'S NAME:		DO YOU OR YOUR SPOUSE HAVE OTHER HEALTH INSURANCE COVERAGE FOR ANY OF THESE EXPENSES? ❑ Yes, please provide data below ❑ No	
ADDRESS:		OTHER INSURANCE NAME:	OTHER POLICY NUMBER:
CITY: STATE: ZIP:		OTHER INSURANCE ADDRESS:	

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

SIGNATURE OF INSURED: DATE:

HEALTH CLUB MEMBERSHIPS: (excluding initiation fees)

DATES OF SERVICE	TYPE OF MEMBERSHIP	CHARGES	NAME OF FACILITY
FROM _____ TO	❑ SINGLE ❑ FAMILY MEMBERSHIP		
FROM _____ TO	❑ SINGLE ❑ FAMILY MEMBERSHIP		

OTHER WELLNESS PROGRAM TOPICS

DATES OF SERVICE	DESCRIPTION OF SERVICE	CHARGES	NAME OF FACILITY
FROM _____ TO			
FROM _____ TO			

WPS HEALTH INSURANCE®
Wisconsin Physicians Service Insurance Corporation
1717 W. Broadway – P.O. Box 8190 – Madison, WI 53708-8190

18210-031-0903