Wisconsin Physicians Service Insurance Corporation
1717 W. Broadway | P.O. Box 8190 | Madison, WI 53708-8190

Wellness Claim Form

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

WPS Health Insurance | Attn: Claims Department | P.O. Box 8190 | Madison, WI 53708 | Fax: 608-223-3626

MATCWellness@wpsic.com | Customer Service | WPS 800-223-6048 | Arise 800-223-6029

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			