Waiver

You have received this form because you indicated that you are unable to participate in the Oxford® Sweat Equity program. Please ask your physician or health care provider to verify the reason.

Then, mail this form and your completed Sweat Equity Program Reimbursement form to:

Oxford Sweat Equity Reimbursement Program
P.O. Box 31386
Salt Lake City, UT 84131

These documents must be mailed to us (postmarked) no later than 180 days from your program end date.
Requests postmarked after this date won't be reimbursed.

Electronic reimbursement request

You have the option to make your Sweat Equity reimbursement request online if you do not wish to make the request by mail. To make the request online:

1. Sign in to **myuhc.com®**
2. Click **Claims & Accounts**
3. Click **Submit a Claim**
4. On the **Medical** tile, click **Start a claim** and fill in the required information

Patient/member information		
First Name:	Last Name:	Date of Birth (Month/Day/Year):

Is the patient the plan Subscriber? (Yes/No):

If no, what is the patient's relationship to the plan subscriber? (e.g., spouse/domestic partner):

Employer/Company Name:	Member ID No.:

Street Address:

City:	State:	ZIP Code:

Sweat Equity program 6-month period	
Start Date:	End Date:

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continued

Verification

(For health care provider use only)

Please provide an explanation below as to why your patient cannot participate in the Sweat Equity program and the time frame of non-participation. The program offers reimbursement to certain members, as specified in the member's benefit plan documents, of a portion of their expenses paid for cardiovascular workouts. Under the program, members are asked to complete a total of 50 cardio workouts — either through fitness facility visits, classes, organized events (e.g., marathon) or a combination of these options — in a 6-month period.

Reason:

Time period unable to participate*: _____/_____/_____ – _____/_____/_____ (month/day/year)

*Time period not to exceed one year. A new form is required each year.

Signature (form must be signed)

Signature of Health Care Provider:		Date:
Name Printed or Official Stamp:		
Phone Number:		
Street Address		
City:	State:	ZIP Code:
DEA # (Optional with Official Stamp):		

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***This completed waiver and program reimbursement form must be mailed to us (postmarked) no later than 180 days from the last date of the 6-month program period you indicate above.**