3786 Broadway
Cheektowaga, NY 14227
(716) 601-7980

Labor-Management Healthcare Fund (LMHF) is the administrator of health, prescription, and dental coverage.
It is our goal to help ensure your overall satisfaction with our program, plans of benefits offered, performance of insurance carriers, and all customer service conduct.

Employee Verification
LMHF Part I Wellness Incentive Program

Instructions:

Please complete the information below, have your physician complete and sign the reverse side and return to the Labor-Management Healthcare Fund office.
Faxes Not Accepted.

DO NOT return documents to your employer.

I hereby confirm that I have completed Part I (Annual Physical) resulting in eligibility for receipt of a Health Related Expenses (debit) card. I understand that this document will be confirmed by the LMHF prior to receiving my card. My HRA card will be delivered to me via U.S. mail within 3 to 4 weeks. You will be notified directly if the LMHF office is unable to confirm your documentation.

Applicant's Signature: ______________________________
Printed Name: ______________________________
Date Signed: ______________________________
Date of Birth: ______________________________
BCBS Member (ID) Number: ________ ____________________
Prefix (Ex. 01, 02) *ID Number*
BCBS Group Number*: ______________________________
Home Address: ______________________________
House Number & Street *Apartment #*
____
City & State *Zip Code*
Phone Number with Area Code: ______________________

*Your BCBS Prefix, Member ID and Group numbers appear on your BCBS identification card.

Subscriber's Information

Union Affiliation: ______________________
Employer Name: ______________________
Department: ______________________

Reverse Side Must be Completed by Physician

Annual Physical Verification
For Part I - LMHF Wellness Incentive Program

I hereby confirm that I am the Physician for ______________________________,
(Patient Name – *please print*)

BlueCross BlueShield Member Identification Number _____________________.

This patient presented on _______________, _____, 20___ and received their
(Month) (Day) (Year)

Annual Physical Examination.

Physician Signature: ____________________________

Physician's Printed Name: ____________________________

Date Signed: ____________________________

Original Signatures are Required. Faxed Copies Not Accepted

Reverse Side (Page 1) Must be Completed by Employee