Health First
Health Plans

Healthy Lifestyle Rebate Contract

6450 U.S. Highway 1, Rockledge, FL 32955
Toll-free 800.716.7737
myHFHP.org

SECTION 1 Must be completed upon initial PCP visit and submitted within 90 days of effective date:

Name: _____ Company: _____

Date: _____ Gender: _____ Age: _____ Health First Member ID #_____

I am the primary holder of the Health First health benefit plan in the year the lifestyle rebate becomes effective.
Patient's Initial: _____

To be completed and signed by Primary Care Physician:

Print PCP's Name: _____

Weight _____ BMI _____ Smoker _____ Non-Smoker _____

Comments: _____ _____
Primary Care Physician's Signature / Date

SECTION 2 Must be submitted within 30 days before group's anniversary date:

Print PCP's Name: _____

Weight _____ BMI _____ Smoker _____ Non-Smoker _____

Comments: _____ _____
Primary Care Physician's Signature / Date

Employee Instructions

Your employer is participating in the Healthy Lifestyle Rebate program*. To make sure this form is completed accurately and on time, please:

- Bring this form with you to your Primary Care Physician (PCP) within 90 days of your group's effective date or your initial date of enrollment (whichever comes first).
  - Consultation must be completed by your PCP—it will not be accepted if completed by a specialist.
  - Any cost share associated with this visit will be waived. However, your PCP may require a copayment up front. If cost share or copayment is applied AND the visit was purely a consultation for only the items listed in the form above, you may contact our Customer Service Department at 321.434.5665 or 800.716.7737 weekdays from 8 a.m. to 8 p.m., or Saturdays from 8 a.m. to noon. Customer Service will verify that your group is participating in this program and that your visit was purely consultative and the claim will be reprocessed. Your provider will be responsible for refunding payment.
  - Your PCP only needs to fill out the top portion of the form during the initial visit.
  - Provide a copy of the completed form to your Group Administrator via fax to 321.434.4362. (Your Group Administrator is responsible for tracking participation in the program).
- Keep a copy of this form in a safe place until 30 days prior to your group's anniversary date. Within 30 days of your group's anniversary date, the bottom section of the form must be completed by your PCP.
  - Provide a copy of the completed form to your Group Administrator to fax to 321.434.4362.

Please contact your employer for additional details and information. Exclusions and limitations may apply. Misrepresentation may result in disqualification from program and/or coverage. Health First Commercial Plans, Inc. is doing business under the name Health First Health Plans. Health First Health Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.
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