



Healthy Lifestyle Rebate Contract

6450 US Highway 1, Rockledge, Florida 32955
Toll-free 844.522.5279
www.myFHCA.org

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

Name: _____ Company: _____
Date: _____ Gender: _____ Age: _____ FHCA Member ID # _____

I am the primary holder of the Florida Hospital Care Advantage 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 844-522-5279 or 800-716-7737 weekdays from 8 am to 5 pm. 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 to 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. Florida Hospital Care Advantage is administered by Health First Health Plans. Group HMO and POS health benefit plans are underwritten by Health First Health Plans, Inc. HLR FORM (11/14)