MIAMI UNIVERSITY
HEALTHY MIAMI – BENEFITS & WELLNESS

2019 Alternate Proof of Care
FAX Cover Sheet

You must include your Explanation of Benefits (EOB) from an insurance company, or documentation from your medical provider.

Attached required documentation must include your name, type of service, and date of service. It should not include any medical results or information.

Date: _____ **Number of Pages (including cover):** _____

Your Name (please print):_____

Are you the subscriber for Miami's health plan (health premium deducted from *your* paycheck)?

YES. Enter your MU uniqueID: _____
(This is your Miami uniqueID, for example, employjn)

NO. Enter your MU uniqueID: _____
(This is your spouse's MU uniqueID followed by "_sps", for example employjn_sps**)**

Your MU uniqueID can be found in your Healthy Miami account under "My Profile."

Birth date: _____/_____/_____

Your email: _____

Your phone: (_____)_____

You may use this option if:

a. You completed a preventive screening or Primary Care Physician (PCP) wellness visit within the required timeframe before you were covered under Miami's UMR health plan.
b. You have completed a preventive screening but the claim was not filed with UMR.
c. You used a provider that does not file claims.

I am including required documented proof of care to satisfy the following Healthy Miami step(s):

- ☐ Primary Care Physician (PCP) Wellness Visit
- ☐ Preventive screening-breast cancer
- ☐ Preventive screening-cervical cancer
- ☐ Preventive screening-colon cancer

Submit to TriHealth: Fax to 513-852-7491 or email to MiamiScreenings@trihealth.com

Please keep a copy of this form for your records.