UCare Enrollment Form

Member Name ____

UCare ID# ____________________________________ Date of Birth _____/_____ /_____

Address ____

City ____ State________ Zip ____________

Home Phone ____________________________ Work Phone ____________________________

E-Mail ____

Member Authorization of Credit:

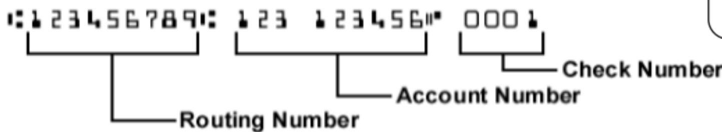
Type of Account:

☐ **Checking** (attach voided check below)

☐ **Savings** (attach savings deposit slip below)

Routing Number________________________

Account Number ______________________



Sample Card of Eligible Member:

ucare

ucare.org

Issuer: **80840**
Name: **JOHN Q DOE**
ID: **123456789**
RxBIN: **003858** RxPCN: **MD** RxGrp: **MNUA**
Svc Type: **MEDICAL/DENTAL**
Group Number: **xxxxxx**
Care Type: **UCare Group Basic**
H2459 801

MedicareRx
Prescription Drug Coverage

OV $xx/**SP** $xx/**UC** $xx/**ER**$xxx Issued: **MM/DD/YYYY**

FOR MEMBER USE – For emergency care go to the nearest hospital or call 911.
Customer Service: 612-676-6840 or 1-877-447-4385, TTY: 612-676-6810 or 1-800-688-2534
UCare 24/7 Nurse Line: 1-888-778-8204, TTY: 1-855-307-6976
Delta Dental Customer Services: 651-768-1416, TTY users call State Relay 711, 1-855-648-1416
Behavioral Health Services: 612-676-6533 or 1-833-276-1185
TruHearing: 1-833-750-5896
Appeals and Grievances: Call UCare: 612-676-6841 or 1-877-523-1517,
TTY: 612-676-6810 or 1-800-688-2534
FOR PROVIDER USE – MN primary claims must be submitted electronically.
For outside MN submit claims to UCare, P.O. Box 70, Minneapolis, MN 55440-0070.
Prescription drug claims must be submitted electronically to Express Scripts.
Submit chiropractic claims to: Fulcrum Health, Inc.,
P.O. Box 981808, El Paso, TX 79998-1808
Provider Assistance Center: 612-676-3300 or 1-888-531-1493
Express Scripts Help Desk for Pharmacies: 1-800-922-1557
Dental: Delta Dental of Minnesota, P.O.Box 9120, Farmington Hills, MI 48333-9120

One Pass

For Fitness Center Use ONLY: ☐ **New Enrollment** ☐ **Change in Insurance/Employer Info** ☐ **Change in Bank Account Info**

Fitness Center Name ____ Club #____________________

Fitness Center Member____ Monthly Average Dues $____________

Member Initials:

_____ A. I understand that I may have a visit requirement and it is my responsibility to ensure my visit is recorded at the time of my workout. I also understand my workout must happen inside the facility and/or within that facility's supervised programming. Only 1 workout per day is counted per person.

_____ B. I understand there will be a period of time between the completed month and the applied credit. Example: Member works out **12** days in January, verified in February, credit applied to account by the end of February.

_____ C. I understand the reimbursements issued cannot exceed the total monthly membership for the month the credit is applied.

_____ D. I understand that canceling my fitness center membership may result in forfeiture of any unapplied credits. All applied credits will be reimbursed to the out-going member(s).

_____ E. I understand that it is my responsibility to ensure that my visit is recorded at the time of my workout.

I understand the above statements and authorize the above fitness center to process credit entries to the account indicated above. This authorization will remain in effect until I notify the above fitness center to discontinue the electronic deposit of funds.

Signature ____ Date ________/________/________

IMPORTANT: If at any time your information changes, please update the fitness center or go online to NIHCArewards.org to ensure your profile is accurate.