Risk Management

500 S. Grand Central Pkwy., Las Vegas, NV 89155-1111
Email: CCRMHealthBenefits@ClarkCountyNV.gov
Office: 702-455-4544 | Fax: 702-455-3084 | ClarkCountyNV.gov

Clark County Self-Funded Benefit Plan
Wellness Benefit Designation Form

Member Name: _____

Patient Name: _____

Member ID Number: _____

The Plan provides a wellness benefit up to $200.00 per calendar year for the following routine services for each covered employee/retiree, covered spouse and covered dependent. This benefit may not be accumulated from year to year if the benefit is not used. An itemized statement must be submitted in order to receive this benefit. For the submission of medications for smoking cessation or weight loss; the medication must be recognized and approved by the FDA for the treatment of smoking cessation or weight loss; receipts must be from a pharmacy and include the name of the drug, patient's name, date dispensed, and amount of purchase. This benefit does NOT cover deductibles, co-payments, co-insurance or any amount over reasonable and customary applied by the plan.

(1) Eyeglasses or contact lenses (not covered by vision plan) - www.eyemed.com or 866-800-5457
- EyeMed explanation of benefit's (EOB) and/or coverage verification **MUST** be attached
- Invoice/receipt from vison provider is also needed when submitting for eyeglasses or contact lenses

(2) Vitamin B injections administered and supplied by a medical provider

(3) Programs to stop smoking as approved or prescribed by a physician

(4) Weight loss program as approved or prescribed by a physician

(5) Check-ups (including routine physical examination, lab tests & x-rays) or immunizations not covered under the Preventive and Wellness Services as specified by the Affordable Care Act.

(6) Wig (Cranial Prosthesis) due to hair loss caused by Chemotherapy Treatments

**Wellness claims filed more than 12-months after the date of service will not be eligible*

I hereby certify that I would like the following expenses applied to my wellness benefit.

Wellness Service Description: _____

Amount to be applied to Wellness Benefit: _____

Date of Service: _____

Provider of Service: _____

Claim Number (if known): _____

Pay the above amount to: Member ◉ Provider ○
(If left blank, the amount will default and be paid to the provider of service)

_____ _____
Signature Date

Please submit your completed form and back up documentation to:

UMR - Clark County Self-Funded Plan
Email: umr_clarkwellness@umr.com
Mail: PO Box 211762 Eagan, MN 55121
Fax: 702-455-3084

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