Office of the County Manager
Office of Risk Management

500 S Grand Central Pky 1st Fl • Box 551711 • Las Vegas NV 89155-1711
(702) 455-4544 • Fax (702) 455-3084

Les Lee Shell, Chief Administrative Officer

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, ANY co-payments, ANY co-insurance or any amount over reasonable and customary applied by the plan.

(1) Eyeglasses or contact lenses (not covered by vision plan)
a copy of the EyeMed Vision Care denial form and/or explanation of benefit MUST be attached
(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) Minor outpatient surgical procedures
(6) 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.
(7) Wig (Cranial Prosthesis) due to hair loss caused by Chemotherapy Treatments

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 be defaulted to pay to the provider of service)

_____ _____

Signature Date

Please mail your completed form and back up documentation to:
Clark County Self-Funded Plan – HealthSCOPE Benefits
P.O. Box 99005 Lubbock, TX 79490-9005
Or email to: clarkcountywellness@healthscopebenefits.com