



# Diocese of Palm Beach

## Confirmation of Life Line Screening



As a value-added benefit of the Diocese Wellness Program, **effective April 1, 2023**, we are pleased to offer employees covered under our diocesan medical plan, Florida Blue Standard and Premium PPOs, and their covered dependents, reimbursement of up to a **maximum of \$179**, per calendar year, per covered individual, for the cost of the certain preventive screenings offered by Life Line Screening. The eligible employee and/or dependent will be responsible for paying for the service in full prior to or at the time of the screening. Pursuant to this program, they may be eligible to be reimbursed up to \$179 for specific preventative screenings at Life Line. Should the covered individual choose additional or alternative screenings offered by Life Line outside this program, they will be responsible for those payments in full and will not be eligible for reimbursement. Life Line Screening does NOT ACCEPT Florida Blue Insurance. This is a reimbursement program for specified preventative screenings and all signatory requirements must be completed along with a Life Line receipt attached to this form. **If a discounted rate is offered or additional screenings are added as complimentary, only the out of pocket cost incurred by the eligible employee/dependent will be reimbursed.** Covered individuals may only be eligible to receive up to the \$179 reimbursement for the following preventative screenings offered by Life Line: **1. Carotid Artery; 2. Abdominal Aortic Aneurysm; 3. Peripheral Arterial Disease; and 4. EKG to detect Atrial Fibrillation – irregular heartbeat.**

Covered employees/dependents may select any location offered by Life Line for the screening. Covered individuals should call **1-800-679-5191** or register online at <https://llsa.social/HSC> . The “Community Circle” discount program has been discontinued by Life Line Screening.

In order to receive the reimbursement, this form **must be signed by the covered employee**, and, if applicable, for an adult dependent, signed by the covered eligible dependent, as **proof of completion** of the actual screening. Proof will be considered the receipt you receive from Life Line for payment **AND** this form signed by the covered employee (and, if applicable, the covered dependent) **and the representative of Life Line Screening that is present at the testing location.**

Once screening is completed and the form is signed, the form shall be submitted to the diocesan Benefits Office for review and processing of the reimbursement. Please note that we cannot process the reimbursement if all of the requirements stated above are not complied with. After processing is completed, the eligible employee will receive a check by mail up to the maximum allowed reimbursement amount.

The form must be submitted and received in the Diocese of Palm Beach Benefits Office within **thirty (30) days** of the date of the screening or reimbursement will be voided and waived.

Your results will not be provided to the diocese. **The results are confidential and protected under HIPAA.**

I certify and confirm that I (EMPLOYEE - PRINT NAME) \_\_\_\_\_ and/or my eligible dependent(s) (PRINT NAME) \_\_\_\_\_ has coverage on the date of service under the Diocese of Palm Beach Health Insurance coverage provided through Florida Blue, completed the preventative screening(s) provided by Life Line Screening on (date) \_\_\_\_\_. I have attached a copy of the payment receipt to verify reimbursement and out of pocket expenditures in the amount of \$ \_\_\_\_\_. I understand that I am responsible for the cost of any preventative screenings outside of this program and that the program will only reimburse me up to \$179 for eligible screenings. I further attest that the information provided on this form is true and accurate.

\_\_\_\_\_  
Signature (Employee)

\_\_\_\_\_  
Signature (Eligible Dependent)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**For Life Line Screening Staff Only - Confirmation of screening:**

\_\_\_\_\_  
**Life Line Screening Staff Signature**

\_\_\_\_\_  
**Life Line Screening Staff – Print Name**

\_\_\_\_\_  
**Date**