MASSACHUSETTS

Fitness Reimbursement Request[1]

PLEASE PRINT ALL INFORMATION CLEARLY IN BLACK INK

To verify this reimbursement is offered within your plan, please log on to MyBlue® at bluecrossma.com/myblue or call the Member Service number on your ID card. You have until March 31 of the following year to submit this form.

Subscriber Information (Policyholder)

Identification Number on Your ID Card (including first 3 characters)	Subscriber's Last Name	First Name	Middle Initial

Address—Number and Street	City	State	Zip Code

Employer's Name

Member and Claim Information

Member's Last Name	First Name	Middle Initial	Date of Birth: MM/DD/YY

Mailing Address—Number and Street (if different from subscriber's)	City	State	Zip Code

Gender (color in the entire box)

☐ Male

☐ Female

Claim is for (choose one and color in the entire box):

☐ Subscriber (policyholder) ☐ Ex-Spouse ☐ Other (specify) _____

☐ Spouse (of policyholder) ☐ Dependent (up to age 26)

Name, Address, and Phone Number of Qualified Fitness Program

Total dollars requested: $_____ for (choose one and color in the entire box):

☐ Membership fees. My monthly membership fee is $_____.

☐ Fitness class fees. My fee per class is $_____.

Health Plan Year

1.Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within 30 calendar days of receiving a completed request for coverage or payment.

Certification and Authorization (This form must be signed and dated below.)

I authorize the release of any information to Blue Cross Blue Shield of Massachusetts about my qualified fitness program. I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services. I certify that I regularly use the qualified program for which I'm requesting reimbursement. I understand that Blue Cross may require additional evidence of program participation and proof of payment before reimbursement is provided.

Subscriber's or
Member's Signature: _____ Date: ____/____/____

Questions?

To verify this fitness reimbursement is offered within your plan or for further information, please log onto the **MyBlue** website at bluecrossma.com/myblue or call the Member Service number on the front of your ID card.

Complete this form and mail it to:

Blue Cross Blue Shield of Massachusetts
Local Claims Department
PO Box 986030
Boston, MA 02298

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID Card (TTY: **711**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

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