Weight-Loss Reimbursement Form[1]

To verify this reimbursement is within your plan, log on to MyBlue at **www.bluecrossma.com/myblue** or call the Member Service number on your ID card. Submit this form when you have paid receipts from a qualified weight-loss program, once per calendar year, no later than March 31 of the following year.

PLEASE PRINT ALL INFORMATION CLEARLY

Subscriber Information (Policyholder)

Identification Number (including first 3 letters)	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: Mo. Day Yr.

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

Gender
☐ Male
☐ Female

Claim is for (check one):
☐ Subscriber (policyholder) ☐ Ex-Spouse ☐ Other (specify) _____
☐ Spouse (of policyholder) ☐ Dependent (up to age 26)

Class or Program Information Required:
Attach 8.5" x 11" photocopies of paid receipts from your qualified weight-loss program. Receipts must show Blue Cross Blue Shield of Massachusetts member's name, name or logo of program, amount paid per session(s), and date(s) paid. For qualified Weight Watchers programs, a photocopy of your program Membership Book showing this information is required.

Name and Address of Class or Program	Health Plan Year

Total Amount Submitted: $ _____

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

I authorize the release of any information to Blue Cross and Blue Shield of Massachusetts, Inc. about my weight-loss 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.

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

Questions?

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

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.

Please complete and mail this form (including copies of paid receipts) to:
Blue Cross Blue Shield of Massachusetts
Local Claims Department
PO Box 986030
Boston, MA 02298

MASSACHUSETTS

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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