WEIGHT LOSS BENEFIT FORM

PLEASE PRINT ALL INFORMATION CLEARLY

DO NOT WRITE IN THIS SPACE
OFFICE USE ONLY

SUBSCRIBER INFORMATION (Person in whose name coverage is held)

Identification Number (including alpha prefix)	Subscriber's Last Name	First Name	Middle Initial
Address—Number and Street	City	State	Zip Code
Employer's Name			

MEMBER INFORMATION

Member's Last Name	First Name	Middle Initial	Date of Birth: Mo. / Day / Year
Mailing Address (if different from subscriber's) Number and Street	City	State	Zip Code

Gender
1. ☐ Male
2. ☐ Female

Claimant is (check one):
1. ☐ Subscriber (coverage holder)
2. ☐ Spouse (of coverage holder)
3. ☐ Child (age 21 or younger)
4. ☐ Handicapped Dependent

WHEN TO SUBMIT THIS FORM:

- **After** you have collected up to $150 in paid receipts from your qualified weight loss program.
- **Once per calendar year, filed by March 31 of the following year.**

CLASS/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/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/Program	Benefit Year*

* A 12-month period beginning January 1 and ending December 31.

Questions?

For further information, call us at **1-800-433-7766**.

TOTAL NUMBER OF RECEIPT COPIES ATTACHED: _____ 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/Member's Signature: _____ Date: _____

Please tear off, fold, and mail this form (including copies of paid receipts) to:
Blue Cross Blue Shield of Massachusetts
Federal Employee Program Claims Department
PO Box 55380
Boston, MA 02205-8338

® Registered Mark of Weight Watchers International, Inc.