



When you claim your Weight Loss Benefit, please mail this form directly to:

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

Remember, to be eligible for reimbursement:

- You must have coverage for the benefit. (Call the Member Service number on the front of your ID card if you have any questions.)
- Submit only once per calendar year, filed by March 31 of the following year, with 8.5" x 11" photocopies of dated, paid receipts. 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.

Have you...

- ☐ written your Blue Cross Blue Shield ID number in the space provided?
- ☐ included the name and address of the weight loss class or program?
- ☐ signed and dated the completed Weight Loss Benefit Form?

Questions?

For further information, call Member Service at the number shown on the front of your ID card.



MASSACHUSETTS

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HMO Blue, Inc.
#74609M

32-8670 (3/07) 300M

Weight Loss

B E N E F I T



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Living

a long and healthy life means something different for everyone. If being in your best health means better managing and maintaining your weight, then we've got a very healthy incentive: our Weight Loss Benefit.

What is the Weight Loss Benefit?

When you, or a covered family member, enroll in a qualified Weight Watchers® or a hospital-based weight loss program, you can receive up to \$150 per calendar year toward your program fees.



If you have a Blue Cross Blue Shield managed care plan, we've got a healthy incentive for you.

As a subscriber to HMO Blue®, Blue Choice®, Blue Care® Elect, or one of our employer-specific managed care plans, your Weight Loss Benefit can save you or your family up to \$150 per calendar year in qualified weight loss program fees. And you can claim your Weight Loss Benefit once you've paid for your program, and your employer has added this benefit to your plan.

What kinds of programs qualify?

Traditional Weight Watchers meetings, The Weight Watchers At Work program, and hospital-based weight loss programs qualify for the Weight Loss Benefit.

The Weight Watchers Online and Weight Watchers At Home programs do **not** qualify for the benefit, nor do fees paid for any other weight loss programs. Fees paid for individual nutrition counseling sessions, food, books, videos, scales, or other items not included as part of the fee for the course or class do **not** qualify.



What do I need to do?

First, check to ensure that your coverage includes the Weight Loss Benefit. If you have any questions, call the Member Service number on the front of your ID card.

Second, enroll in a qualified weight loss program. You must pay for the course or program first, and may then submit for the benefit.

Simply send us:

- **The Weight Loss Benefit Form**, answering all questions. (Please note that the \$150 is per individual or family membership, per calendar year.)
- **8.5" x 11" photocopies of paid receipts** from the qualified program in which you enroll. 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.

Then mail both the form and copies of your receipts to the address at the bottom of the Weight Loss Benefit Form.

If you have any questions, please call the Member Service number on your ID card.

Note: Please keep your original receipts before sending copies with your claim. Services denied for payment will be noted on your claim summary. We do not return any receipts or claim forms.

Be sure to check with your physician before getting started with any weight loss program.



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		Date of Birth: Mo. / Day / Year	
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)		Address—Number and Street		City		State		Zip Code	
Gender		Claimant is (check one):							
1. <input type="checkbox"/> Male		1. <input type="checkbox"/> Subscriber (coverage holder) 3. <input type="checkbox"/> Child (age 19 or younger) 5. <input type="checkbox"/> Student (age 19 or older)							
2. <input type="checkbox"/> Female		2. <input type="checkbox"/> Spouse (of coverage holder) 4. <input type="checkbox"/> Handicapped Dependent (age 19 or older) 6. <input type="checkbox"/> Stepchild 7. <input type="checkbox"/> Other (specify) _____							
WHEN TO SUBMIT THIS FORM:									
• After your employer has added the benefit. (Check with your employer, if necessary, to verify the date when coverage was added.)									
• 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"x11" 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 Health Club									

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
Local Claims Department
PO Box 986030
Boston, MA 02298