Fitness Reimbursement Form[1]

To verify this reimbursement is within your plan, please log on to Member Central at **www.bluecrossma.com/membercentral** or call the Member Service number on your ID card. Submit this form 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)
- ☐ Spouse (of policyholder)
- ☐ Ex-Spouse
- ☐ Dependent (up to age 26)
- ☐ Other (specify) _____

Name, Address, and Phone Number of Qualified Health Club

I am due $_____ for the following reimbursement (check one):

- ☐ Membership at a qualified health club. My monthly fee is $_____.
- ☐ Fitness classes at a qualified health club. My fee per class is $_____.

Health Plan Year

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 health club membership. 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 understand that Blue Cross may require additional evidence of health club membership and proof of payment for my membership before reimbursement is provided.

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

Questions?

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

Please complete and mail this form to:
Blue Cross Blue Shield of Massachusetts
Local Claims Department
PO Box 986030
Boston, MA 02298

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

130440M 55-0763 (10/14)

MASSACHUSETTS