

Weight-Loss Reimbursement Form¹

To verify this reimbursement is within your plan, log on to Member Central at www.bluecrossma.com/membercentral 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Claim is for (check one): <input type="checkbox"/> Subscriber (policyholder) <input type="checkbox"/> Ex-Spouse <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Spouse (of policyholder) <input type="checkbox"/> 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 Member Central website at www.bluecrossma.com/membercentral or call the Member Service number on the front of your ID card.

1. Blue Cross 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

