MASSACHUSETTS

Weight-Loss Reimbursement Request[1]

PLEASE PRINT ALL INFORMATION CLEARLY IN BLACK INK

To verify this reimbursement is offered within your plan, please log on to MyBlue® at bluecrossma.com/myblue or call the Member Service number on your ID card. You have until March 31 of the following year to submit this form.

Subscriber Information (Policyholder)

Identification Number on Your ID Card (including first 3 characters)	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: MM/DD/YY

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

Gender (color in the entire box)

☐ Male

☐ Female

Claim is for (choose one and color in the entire box):

☐ 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, Address, and Phone Number of Qualified Weight-Loss Program	Health Plan Year

Total dollars requested: $ _____

My monthly program participation fee is $ _____

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.

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 qualified 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. I certify that I regularly use the qualified program for which I am requesting reimbursement. I understand that Blue Cross may require additional evidence of program participation and proof of payment before reimbursement is provided.

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