MASSACHUSETTS

WEIGHT-LOSS REIMBURSEMENT REQUEST

PLEASE PRINT ALL INFORMATION CLEARLY

To verify this reimbursement is offered within your plan, or for more information, please sign in to MyBlue at **bluecrossma.org** or call the Member Service number on your ID card.
All weight-loss reimbursement requests must be submitted by March 31 of the following year.

Subscriber Information (Policyholder)

Identification Number on Subscriber 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

Claim Information

Member's Last Name	First Name	Middle Initial	Date of Birth (MM/DD/YY)

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)

Name, Address, and Phone Number of Qualified Weight-Loss Program

Total dollars requested: $ _____

Monthly program participation fee: $ _____

Year Fees Paid:

Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within 30 calendar days of receiving a completed request form. Reimbursement is sent to the member's address on file with Blue Cross. Reimbursement may be considered taxable income, so consult your tax advisor.

Certification and Authorization (This form must be signed and dated below.)

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 enrolled in the qualified program with the full intention of using such program. I understand that Blue Cross Blue Shield of Massachusetts may require proof of payment for a reimbursement decision. I authorize the release of any information about my qualified weight-loss program to Blue Cross Blue Shield of Massachusetts.

Subscriber Signature:	Date (MM/DD/YY)

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

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