Weight-Loss Reimbursement Form[1]

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

☐ Male
☐ Female

Claim is for (check one):

☐ 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 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.

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

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

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MASSACHUSETTS