

# Fitness Reimbursement Form<sup>1</sup>

To verify this reimbursement is within your plan, please log on to Member Central at [www.bluecrossma.com/membercentral](http://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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Claim is for (check one): <input type="checkbox"/> Subscriber (policyholder) <input type="checkbox"/> Spouse (of policyholder)	<input type="checkbox"/> Ex-Spouse <input type="checkbox"/> Dependent (up to age 26)	<input type="checkbox"/> Other (specify) _____
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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](http://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.

