



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](http://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):			
<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)			
Name, Address, and Phone Number of Qualified Weight-Loss Program			
Total dollars requested: \$ _____			Year Fees Paid:
Monthly program participation fee: \$ _____			

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)
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#### Complete this form and mail it to:

Blue Cross Blue Shield of Massachusetts Local Claims Department  
PO Box 986030  
Boston, MA 02298

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).