



MASSACHUSETTS

Weight-Loss Reimbursement Request¹

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) <input type="checkbox"/> Male <input type="checkbox"/> Female	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)			

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: ____/____/____

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).