



MASSACHUSETTS

# WEIGHT-LOSS REIMBURSEMENT

**Your reward for healthy behavior:**  
Receive up to \$150 annually when you participate in a qualified weight-loss program.<sup>1</sup>



## Qualified for Weight-Loss Reimbursement

### Participation fees for:

- Hospital-based programs and Weight Watchers® in-person
- Weight Watchers online and other non-hospital programs (in-person or online) that combine healthy eating, exercise, and coaching sessions with certified health professionals such as nutritionists, registered dietitians, or exercise physiologists.



## Not Qualified for Weight-Loss Reimbursement

- One-time initiation or termination fees
- Food, supplements, books, scales, or exercise equipment
- Individual nutrition counseling sessions, doctor/nurse visits, lab tests, or other services that are covered benefits under your medical plan

## GET REIMBURSED IN THREE EASY STEPS

1

### Choose

Start by picking a qualified weight-loss program.

2

### Complete

Once you pay for the program, fill out the attached form, or sign in to MyBlue to submit online at [member.bluecrossma.com/login](http://member.bluecrossma.com/login).

3

### Mail

Send the completed form to the address listed.

**Be sure to check with your doctor before starting any weight-loss program.**

1. To verify this reimbursement is offered for your plan, or for more information, sign in to MyBlue at [bluecrossma.com/myblue](http://bluecrossma.com/myblue) or call the Member Service number on your ID card. Most plans offer the reimbursement shown, but refer to your plan information for specific details.

## Questions?

Contact Member Service by calling the phone number on your member ID card.

# 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.com/myblue](http://bluecrossma.com/myblue) 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.

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

## 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 Last Name	First Name	Middle Initial	Gender (color in the entire box) <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth __/__/__
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**Claim is for (choose one and color in the entire box):**

- Subscriber (policyholder)
- Spouse (of policyholder)
- Ex-Spouse
- Dependent (up to age 26)
- Other (specify):

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

**Total dollars requested: \$ \_\_\_\_\_**

**Monthly program participation fee: \$ \_\_\_\_\_**

**Calendar Year: \_\_/\_\_/\_\_**

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 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's or Member's Signature:** \_\_\_\_\_

**Date:** \_\_/\_\_/\_\_

### Important Information:

- Weight-loss reimbursement can be granted for any single member or combination of members enrolled under the same Blue Cross Blue Shield of Massachusetts health plan. Blue Cross will make a reimbursement decision within 30 days of receiving a completed request.
- Reimbursement requests must be submitted by March 31 of the following year.
- Keep copies of proof of payment in case we request it from you. Proof of payment includes:
  - Receipts (cash/check/credit/electronic) for participation fees clearly documenting your name, the weight-loss program name, and individual amounts charged with date paid.
  - Your weight-loss program membership or participation agreement clearly documenting your name and date of enrollment/participation.
- Your reimbursement may be considered taxable income, so consult a tax advisor.

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).