# Fitness Reimbursement Form

To verify this reimbursement is within your plan, please log on to MyBlue at [bluecrossma.com/myblue](http://bluecrossma.com/myblue) 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)

<table>
<thead>
<tr>
<th>Identification Number (including first 3 letters)</th>
<th>Subscriber’s Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address—Number and Street</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
<tr>
<td>Employer’s Name</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Member and Claim Information

<table>
<thead>
<tr>
<th>Member’s Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Date of Birth: Mo. Day Yr.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing Address—Number and Street (if different from subscriber’s)</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Claim is for (check one):</th>
<th>Other (specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Subscriber (policyholder)</td>
<td>Ex-Spouse</td>
</tr>
<tr>
<td>Female</td>
<td>Spouse (of policyholder)</td>
<td>Dependent (up to age 26)</td>
</tr>
</tbody>
</table>

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 $___________________.

**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 MyBlue website at [bluecrossma.com/myblue](http://bluecrossma.com/myblue) or call the Member Service number on the front of your ID card.

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.
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. Límite 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).