Mail to:
Blue Benefit Administrators of Massachusetts
P.O Box 55917
Boston, MA 02205 - 5917

Fitness, Health & Wellness Form

*The below information and examples are **NOT** inclusive, and do **NOT** encompass all information and plan specific requirements for reimbursement. Some plans may require the completion of several classes or months of paid membership prior to reimbursement. The below benefit type choices are not a guarantee that your plan has that specific Wellness, Health or fitness option.* ***Please refer to your Summary Plan Description (SPD) for specific details on your Fitness/Health or Wellness Plan.***

This claim form must be accompanied by a copy of an itemized bill on provider letterhead to be eligible for plan reimbursement. You must complete each of the sections below.

SECTION 1: EMPLOYEE INFORMATION		
NAME	SEX MALE FEMALE	DATE OF BIRTH
STREET ADDRESS	HOME PHONE NO.	
CITY, STATE, ZIP CODE	MEMBER IDENTIFICATION NUMBER	

SECTION I1: CLAIMANT INFORMATION					
NAME		DATE OF BIRTH	SEX MALE FEMALE	RELATION SELF SPOUSE	DOMESTIC PARTNER
STREET ADDRESS			HOME PHONE NO.		
CITY, STATE, ZIP CODE			SOCIAL SECURITY NO.		

SECTION III: BENEFIT TYPE (Please refer to the Summary Plan Description Specific Coverage Details.)

☐ Fitness - *Health club membership fees, fitness classes, personal training with professional instructor, qualified sport teams and leagues*

☐ Weight loss – *Weight loss programs such as Weight Watchers, Jenny Craig, hospital-based programs, Employer sponsored programs*

☐ Health & Wellness – *Weight loss programs, health clubs, massage therapy, hypnotherapy, smoking cessation, Employer sponsored programs*

☐ Fitness & Weight Loss - *Health club membership fees, fitness classes, personal training with professional instructor, qualified sport teams and leagues Weight loss programs such as Weight Watchers, Jenny Craig, hospital-based programs, Employer sponsored programs*

To be eligible for reimbursement the covered person must file a claim and a paid receipt/itemized statement from the rendering provider no later than specified date per plan guidelines found in Summary Plan Description.

Members Statement

I certify that the above is complete and correct and that I am claiming benefits only for charges incurred by the patient above. Authorization is hereby given to any hospital, physician, or other provider which participated in any way in my care and treatment to release to BBA any information which they in their judgment deem necessary to the adjudication of this claim.

Member Name (please print) ______________________________

Member Signature ______________________________ Date ______________________________

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