# Weight Loss

## B E N E F I T

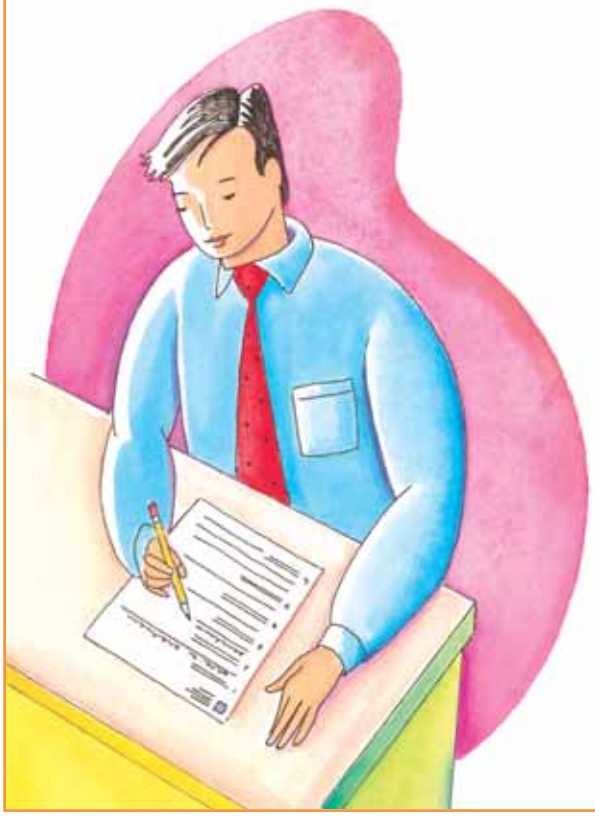
### If you have a Blue Cross Blue Shield of Massachusetts managed care plan, we've got a healthy incentive for you.

As a subscriber to HMO Blue®, Blue Choice®, Blue Care® Elect, or one of our employer-specific managed care plans, your Weight Loss Benefit can save you or your family up to $150 per calendar year in qualified weight loss program fees. And you can claim your Weight Loss Benefit once you've paid for your program, and your employer has added this benefit to your plan.

### What kinds of programs qualify?

Traditional Weight Watchers meetings, the Weight Watchers At Work program, and hospital-based weight loss programs qualify for the Weight Loss Benefit.

The Weight Watchers Online and Weight Watchers At Home programs do **not** qualify for the benefit, nor do fees paid for any other weight loss programs. Fees paid for individual nutrition counseling sessions, food, books, videos, scales, or other items not included as part of the fee for the course or class do **not** qualify.



### What do I need to do?

First, check to ensure that your coverage includes the Weight Loss Benefit. If you have any questions, call the Member Service number on the front of your ID card.

Second, enroll in a qualified weight loss program. You must pay for the course or program first, and may then submit for the benefit.

Simply send to Blue Cross Blue Shield of Massachusetts:

- The Weight Loss Benefit Form, answering all questions. (Please note that the $150 is per individual or family membership, per calendar year.)
- 8.5" x 11" photocopies of paid receipts from the qualified program in which you enroll. Receipts must show Blue Cross Blue Shield of Massachusetts member's name, name/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.

Then mail both the form and copies of your receipts to the address at the bottom of the Weight Loss Benefit Form. If you have any questions, please call the Member Service number on your ID card.

***Note:*** *Please keep your original receipts before sending copies with your claim. Services denied for payment will be noted on your claim summary. We do not return any receipts or claim forms.*

**Be sure to check with your physician before getting started with any weight loss program.**

Blue Cross Blue Shield of Massachusetts

# WEIGHT LOSS BENEFIT FORM

PLEASE PRINT ALL INFORMATION CLEARLY

**DO NOT WRITE IN THIS SPACE**
**OFFICE USE ONLY**

## SUBSCRIBER INFORMATION (Person in whose name coverage is held)

| Identification Number (including alpha prefix) | SUBSCRIBER'S LAST NAME | FIRST NAME | MIDDLE INITIAL |
|---|---|---|---|
| | | | |

| Address — Number and Street | City | State | Zip Code |
|---|---|---|---|
| | | | |

Employer's Name

## MEMBER INFORMATION

| Member's Last Name | First Name | Middle Initial | Date of Birth: Mo. / Day / Year |
|---|---|---|---|
| | | | |

Mailing Address (if different from subscriber's)
Number and Street | City | State | Zip Code

Gender
1. ❑ Male
2. ❑ Female

Claimant is (check one):
1. ❑ Subscriber (coverage holder)
2. ❑ Spouse (of coverage holder)
3. ❑ Child (age 18 or younger)
4. ❑ Handicapped Dependent (age 19 or older)
5. ❑ Student (age 19 or older)
6. ❑ Stepchild
7. ❑ Other (specify) _____

### WHEN TO SUBMIT THIS FORM:

- After your employer has added the benefit. (Check with your employer, if necessary, to verify the date when coverage was added.)
- After you have collected up to $150 in paid receipts from your qualified weight loss program.
- Once per calendar year, filed by March 31 of the following year.

CLASS/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/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 and Address of Class/Program | Benefit Year* |
|---|---|
| | |

*A 12-month period beginning January 1 and ending December 31.

TOTAL NUMBER OF RECEIPT COPIES ATTACHED: _____ TOTAL AMOUNT SUBMITTED: $ _____

CERTIFICATION AND AUTHORIZATION **(This form must be signed and dated below.)**

I authorize the release of any information to Blue Cross and Blue Shield of Massachusetts, Inc., about my 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.

Subscriber's/Member's Signature: _____ Date: _____

**Please tear off, fold, and mail this form (including copies of paid receipts) to:**
Blue Cross Blue Shield of Massachusetts
Local Claims Department
PO Box 986030
Boston, MA 02298

## Questions?

For further information, call the Member Service number shown on the front of your ID card.

Blue Cross Blue Shield of Massachusetts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