

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	Yr.
Mailing Address (if different from subscriber's) Number and Street	City	State	Zip Code		
Gender	Claimant is (check one):				
1. <input type="checkbox"/> Male	1. <input type="checkbox"/> Subscriber (coverage holder)	3. <input type="checkbox"/> Child (age 18 or younger)	5. <input type="checkbox"/> Student (age 19 or older)		
2. <input type="checkbox"/> Female	2. <input type="checkbox"/> Spouse (of coverage holder)	4. <input type="checkbox"/> Handicapped Dependent (age 19 or older)	6. <input type="checkbox"/> Stepchild		
			7. <input type="checkbox"/> 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 the Blue Cross Blue Shield of Massachusetts member's name, name/logo of the 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*
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* 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 print, 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