



# Weight Loss Benefit

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

As a subscriber to Blue Cross Blue Shield of Massachusetts, your Weight Loss Benefit can save you or your family up to \$150 per calendar year in qualified weight loss program fees. You can claim your Weight Loss Benefit **after** you've paid for your program.

## What types 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 a claim for the benefit.

Simply send us:

- **The Weight Loss Benefit Form**, answering all questions. (Please note that the \$150 is per individual or family membership. Submit only once per calendar year, filed by March 31 of the following year.)

- **8.5" x 11" photocopies of paid receipts** from the qualified program in which you enroll. Receipts must show the 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.
- **Finally, 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 starting any weight loss program.*

# 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Claimant is (check one): <input type="checkbox"/> Subscriber (coverage holder) <input type="checkbox"/> Spouse (of coverage holder)		<input type="checkbox"/> Child (age 18 or younger) <input type="checkbox"/> Handicapped Dependent (age 19 or older) <input type="checkbox"/> Student (age 19 or older) <input type="checkbox"/> Stepchild <input type="checkbox"/> Other (specify) _____		

### When to Submit this Form:

- 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*
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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

### Questions?

To verify this benefit is within your plan or for further information, call the Member Service number on the front of your ID card.

