Harvard Pilgrim Health Care

Weight Management Program Reimbursement Form

For Massachusetts members with: 1) individual coverage or 2) coverage through an employer group with 50 or fewer employees. (If you're not sure if you qualify, check with your employer.) Please read the instructions below, then fill out the form on page 2.

Keep copies of all documentation before sending in your Weight Management Program Reimbursement Form.

Mailing Instructions

Please enclose copies of the following:

1. Completed and signed Weight Management Program Reimbursement Form
2. Paid receipts verifying enrollment in a qualifying weight management program (receipts must show name of the member, name of the program, amount paid per session(s), and date(s) paid)
3. Mail the Weight Management Program Reimbursement Form and all documentation to:
   Harvard Pilgrim Health Care
   P. O. Box 9185
   Quincy, MA 02269

Commonly Asked Questions and Answers

How do I qualify for a reimbursement?

- Your plan must include Harvard Pilgrim's Weight Management Program Reimbursement benefit. Check with your employer or see your Schedule of Benefits for details.
- You may only submit for reimbursement once per calendar year, for up to 12 weeks of program membership in that year.

When can I submit my Weight Management Program Reimbursement Form?

You must submit the form before the end of the calendar year following the year for which you are requesting reimbursement.

Does my weight management program qualify?

- To receive reimbursement, you must enroll in a WW (Weight Watchers)® digital program or workshop, or a hospital-based weight management program.
- No coverage is provided for individual nutritional counseling sessions, registration fees, pre-packaged meals, books, videos, scales or other items or supplies bought by the member, or any other items not included as part of a weight management class or course.

How much can I claim for reimbursement?

- Subscribers may claim up to 12 weeks of membership per calendar year (e.g., January-December) in total for the WW (Weight Watchers)® digital program or workshop, or hospital-based weight management program for themselves and/or their dependents.
- Reimbursement may not exceed the cost of 12 weeks of participation in a WW (Weight Watchers)® digital program or workshop, or in a hospital-based weight management program.
- Subscribers may receive weight management program reimbursement only once per calendar year.

What happens once I submit the Weight Management Program Reimbursement Form?

- Reimbursement checks will be made payable to the subscriber and mailed only to the subscriber's address of record. No alternative address will be accepted.
- If you believe your current address is different than the address of record in Harvard Pilgrim's systems, please contact us before submitting your form.
- Please allow up to 8 weeks for processing.

Harvard Pilgrim Health Care

Weight Management Program Reimbursement Form

To be filled out by Harvard Pilgrim Health Care **SUBSCRIBER** only. Please use blue or black ink and print all information clearly.

When to submit this form

- After you enroll in a Harvard Pilgrim plan that includes the Weight Management Program Reimbursement benefit
- After you are a member of an approved weight management program
- Once per calendar year, with all necessary receipts and documentation
- Once all sections on the form have been completed and signed by the subscriber

Section A – Subscriber Information (person who holds coverage)

Harvard Pilgrim ID Number | Subscriber's Last Name | First Name | Middle Initial

Date of Birth (mm/dd/yyyy)

Address | City | State | ZIP Code

Daytime Phone (area code) xxx-xxxx | Company Name (Employer) | Subscriber's Email

Section B – Subscriber and/or Member Information for Reimbursement

Harvard Pilgrim ID Number | Last Name | First Name | Date of Birth (mm/dd/yyyy)

Harvard Pilgrim ID Number | Last Name | First Name | Date of Birth (mm/dd/yyyy)

Harvard Pilgrim ID Number | Last Name | First Name | Date of Birth (mm/dd/yyyy)

Section C – Weight Management Program Information *(List all programs that you are submitting for on behalf of you and/or your dependents, including the qualifying months.)*

ATTACH DOCUMENTATION

Calendar Year **from:** mm/dd/yyyy **to:** mm/dd/yyyy	**Type of Program**	**City, State**	**Phone Number** (area code) xxx-xxxx	**$ Amount being claimed**
from: ____/____/____ **to:** ____/____/_____				
from: ____/____/____ **to:** ____/____/_____				
from: ____/____/____ **to:** ____/____/_____				

Total number of documents _____ Total dollar amount being claimed $_____

Section D – Subscriber Certification

I certify that the information on the form and all supporting documents are complete, accurate and unaltered. I affirm that I will attempt, in good faith, to regularly attend my weight management program and utilize membership for which I am being reimbursed.

Subscriber's Signature | Date

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