Weight-Loss Reimbursement Form

To verify this reimbursement is within your plan, log on to Member Central at www.bluecrossma.com/membercentral or call the Member Service number on your ID card. Submit this form when you have paid receipts from a qualified weight-loss program, once per calendar year, no later than March 31 of the following year.

PLEASE PRINT ALL INFORMATION CLEARLY

Subscriber Information (Policyholder)

<table>
<thead>
<tr>
<th>Identification Number (including first 3 letters)</th>
<th>Subscriber’s Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address—Number and Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

Employer’s Name

Member and Claim Information

<table>
<thead>
<tr>
<th>Member’s Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Date of Birth: Mo. Day Yr.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mailing Address—Number and Street (if different from subscriber’s)</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

Gender
- [ ] Male
- [ ] Female

Claim is for (check one):
- [ ] Subscriber (policyholder)
- [ ] Ex-Spouse
- [ ] Other (specify) ___________________
- [ ] Spouse (of policyholder)
- [ ] Dependent (up to age 26)

Class or 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 or 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.

<table>
<thead>
<tr>
<th>Name and Address of Class or Program</th>
<th>Health Plan Year</th>
</tr>
</thead>
</table>

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 or Member’s Signature: _____________________________ Date: _____________________________

Questions?

To verify this reimbursement is within your plan or for further information, please log on to the Member Central website at www.bluecrossma.com/membercentral or call the Member Service number on the front of your ID card.

1. Blue Cross will make a reimbursement decision within 30 calendar days of receiving a completed request for coverage or payment.

Please complete 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