MEMBER FITNESS REBATE FORM

You must complete all fields. Please print clearly. Retain a copy of all receipts and documents for your records. Please be sure to sign the form.

To qualify for the fitness rebate, you must complete four consecutive months of membership with Tufts Health Plan

You will have 24 months from the date you paid your fitness club fees to submit your request for the fitness rebate. Check your benefits for what is included in the rebate and the amounts allowed on your plan. The rebate applies one time per family, one time per year. The rebate is paid to the Tufts Health Plan subscriber after fitness costs are paid. We usually process reimbursements within 4 to 6 weeks of receipt.

MEMBER/SUBSCRIBER INFORMATION

▶ **Member Information**

Name (Last, First, Middle Initial): _____

Date of Birth: _____ / _____ / _____ Sex: ❑ Male ❑ Female

Tufts Health Plan ID# ☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐

▶ **Subscriber Information**

Address: _____ Telephone: _____

FITNESS CENTER INFORMATION

Fitness Club Name: _____

Address: _____ Telephone: _____

Year(s) of fitness club membership: Year 1: _____ Amount Paid: _____

Year 2: _____ Amount Paid: _____

GROUP EXERCISE CLASS INFORMATION (Check your benefits for this rebate)

Group Exercise Class Name: _____

Address: _____ Telephone: _____

Year(s) of group exercise class(es): Year 1: _____ Amount Paid: _____

Year 2: _____ Amount Paid: _____

FOR INTERNAL USE ONLY

Diagnosis Code: 799 **Description:** General **Procedure code:** T4220 Health club membership, annual

Procedure code: S9451 Group exercise classes

PAYMENT INFORMATION

Please indicate which one of the following forms of proof of payment you are including with this form:

- ❑ **An itemized receipt from the fitness club and/or group exercise class, showing the dates of membership and dollar amounts paid**
- ❑ **A credit card statement or receipt indicating fitness club and/or group exercise class payment**
- ❑ **A statement from the fitness club's and/or group exercise class' letterhead, with an authorized signature, indicating payment was made**

SIGNATURE REQUIRED

I attest that the above information is true and accurate, and the services were received and paid for in the amout requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent, my coverage may be canceled and I may be subject to criminal and/or civil penalties for false health care claims. I also understand that Tufts Health Plan may request any additional information it deems necessary to verify that services were received and payment was made. I understand that the fitness rebate may be considered taxable income.

Member Signature: _____ Date: _____

Please submit this form and all documentation to:
Tufts Health Plan | Member Reimbursement Claims, PO Box 9191
Watertown, MA 02471-9191

Please do not staple any materials to this form

TUFTS Health Plan

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