Tufts Health Direct

Covered Benefit Reimbursement Form:
Weight Loss Programs

TUFTS Health Plan

a Point32Health company

Reward Yourself for Getting Fit

Get reimbursed for up to **3 months** of weight loss program fees!

Weight Loss Program Reimbursement

You can request a reimbursement for a qualified weight loss program. We will cover the first three months, not including any initiation fees or food costs.

Your weight loss program reimbursement must meet the following criteria for the rebate:

1. You must be a Tufts Health Direct member for three months and participate in a weight loss program for at least three consecutive months.

Based Based on your plan type, Tufts Health Plan will pay up to the first three months of your weight loss program costs. The weight loss rebate benefit varies depending on the plan you are on. Please review your member handbook for covered and non-covered services. The member handbook can be found in forms and documents under Handbooks.

Submit your rebate form

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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 weight loss program rebate, you must complete three consecutive months of membership with Tufts Health Plan.

You will have 24 months from the date you paid your weight loss program fees to submit your request for the weight loss program rebate. Each member on a family plan can request a weight loss program reimbursement once per Benefit Year. The rebate is paid to the Tufts Health Plan subscriber. We usually process reimbursements within 6 to 8 weeks of receipt.

Member/Subscriber Information

- Member Information
  Name (Last, First, Middle Initial): _____
  Date of Birth: _____ / _____ / _____
  Tufts Health Plan ID # | | | | | | | | | | | |

- Subscriber Information
  Address: _____
  Telephone: _____

Weight Loss Program Information

Weight Loss Program Name: _____
Address: _____
Telephone: _____

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 weight loss program showing dates of membership and dollar amount paid
- ❑ A statement on the weight loss program's letterhead, with an authorized signature, indicating payment was made

Signature Required

Member Signature: _____
Date: _____ / _____ / _____

Please submit this form and all documentation to:

Tufts Health Plan
Attn: Claims Department
P.O. Box 524
Canton, MA 02021

Or fax to: 857.304.6307

Questions? Call us at **888.257.1985.**