Tufts Health Direct

Covered Benefit Reimbursement Form:
Weight Loss Programs

TUFTS Health Plan

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 approved by your PCP. 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.
2. This reimbursement covers only these weight loss programs: Jenny Craig, Weight Watchers and Nutrisystem.

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.

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. Ask your primary care provider (PCP) to fill out the Provider Information section, fill in the date and sign the form.

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

PROVIDER INFORMATION

Provider Name: _____

Provider Signature: _____

Date: _____ / _____ / _____

SIGNATURE REQUIRED

Member Signature: _____

Date: _____ / _____ / _____

Please submit this form and all documentation to:

Tufts Health Plan
Attn: Claims Department
705 Mount Auburn Street
Watertown, MA 02471-9194

Or fax to: 857.304.6307

Questions? Call us at **888.257.1985.**