Harvard Pilgrim Weight Management Reimbursement Form

Please read the instructions below, then fill out the Weight Management Reimbursement Form.

Mailing Instructions

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

Please enclose copies of the following:

1. Completed, signed and dated Weight Management Reimbursement Form
2. Copy of paid receipts (cash/check/credit/electronic) for fees clearly documenting your name and the weight management program name. Fees must equal or exceed amount being claimed.

Mail to: Harvard Pilgrim Health Care
P. O. Box 9185
Quincy, MA 02269

Commonly Asked Questions and Answers

How do I qualify for a reimbursement?

- You must be active with coverage that includes the weight management program benefit.

Which programs qualify for reimbursement?

Qualifying weight management programs include: Traditional Weight Watchers meetings; Weight Watchers at Work programs; and hospital-based weight loss programs.

Please note that the following **do not** qualify for reimbursement:

- Online weight programs (including Weight Watchers Online).
- Hospital sponsored programs that solely offer pre-packaged meals, weight loss supplies, or online tracking and assistance.
- 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.

When can I submit my Reimbursement Form?

Starting with January 1 of the current calendar year and when you have met the above stated criteria.

How much can I claim for reimbursement?

- Reimbursement is up to $150 per calendar year (e.g., January–December) in total for qualified weight management program fees for the Subscriber and/or their dependents.
- Subscriber may receive weight management reimbursement only **once** per calendar year.

What happens once I submit the Weight Management Reimbursement Form?

- Reimbursement checks will be mailed and made payable to the Subscriber only at 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 prior to submitting your Weight Management Reimbursement Form.
- Please allow up to 8 weeks for processing.

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

Reimbursement program requirements are subject to change without notice.

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Harvard Pilgrim Health Care | NTT DATA Services

Harvard Pilgrim Weight Management 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 have accumulated up to $150 in weight management program expenses.
- *Once per calendar year*, submitted by March 31 of the following year, with all necessary receipts.
- Once all sections of this form have been completed, signed and dated by the Subscriber.
- Programs that qualify: Traditional Weight Watchers meetings, Weight Watchers at Work programs and hospital-based weight management programs.

Section A – Member 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		Member'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 and/or your dependent(s) are submitting for reimbursement

ATTACH DOCUMENTATION

Calendar Year **from:** mm/dd/yyyy **to:** mm/dd/yyyy	**Program Name**	**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** (up to $150 per calendar year) **$**_____

Section D – Member Certification

I certify that the information on this form and all supporting documents are complete, accurate and unaltered.

Subscriber's Signature Date (mm/dd/yyyy)

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