Harvard Pilgrim Health Care

Wellness 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

- When you are eligible for reimbursement through your employer or individual plan.
- After you have been a member in qualified wellness program and Harvard Pilgrim Health Care for at least four months in a calendar year.
- Once per calendar year, submitted by March 31 of the following year, with all necessary receipts or proof of payment.
- After all sections have been completely filled out and signed by the subscriber.

Section A – Subscriber 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 | Company Name (Employer) | Subscriber'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)

Section C – Wellness Program Information (List all wellness and facility memberships that you and/or your dependent(s) are submitting for reimbursement spanning the qualifying four months. Please note only select nutrition and mindfulness programs qualify for reimbursement.

ATTACH DOCUMENTATION

Calendar Year **from:** mm/dd/yyyy **to:** mm/dd/yyyy	**Facility or Program Name**	**City, State address and/or email address**	**Phone Number** (area code) xxx-xxxx	**$ Amount being claimed**
from: ___/___/___ **to:** ___/___/_____				
from: ___/___/___ **to:** ___/___/_____				

Section D – Fitness Equipment

ATTACH RECEIPT

Purchase Date	**Brand/model**	**Cardiovascular equipment**	**Strength training equipment**	**$ Amount being claimed**

Total number of documents: _____ Total dollar amount being claimed : $_____

Section E – Subscriber Certification

I certify the information on the form and all supporting documents are complete, accurate and unaltered. I will attempt, in good faith, to regularly use my fitness services for which I am being reimbursed.

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