Get Fit! Reimbursement Form
MassHealth

WellSense HEALTH PLAN

As a WellSense MassHealth member, your health is our top priority. That's why we offer reimbursements for fitness club memberships and Weight Watchers® programs. This is up to a $300 value!

Who Should Submit this Form?

- Must be a WellSense MassHealth member for at least 3 months in a calendar year before requesting a Weight Watchers, or fitness club reimbursement (must be a member at the same time as purchase, subscription, or membership).
- Reimbursement forms are due by March 31 of the following year. Please allow 6 to 10 weeks from the time you submit your request to receive your reimbursement.

Member Information (Please print information clearly)			
Your member ID number (found on your WellSense ID card)			
Member's last name			
First name	Middle initial		
Address	City	State	Zip code
Phone			

Member Extra(s) Requested	
☐	**Fitness Reimbursement** (Up to $200 back per family) • **Qualifying health clubs:** Traditional health and fitness clubs, YMCAs or YWCAs, and Jewish community centers. • **Non-qualifying health clubs:** Personal training, martial arts centers, tennis or pool-only facilities, gymnastics facilities, country clubs or social clubs, sports teams or leagues.
☐	**Weight Watchers Reimbursement** (Up to $100 back per family)

To be completed by member		
	Amount Requested	**Additional Documentation Needed**
Fitness Club Name:		Attach 8 ½" x 11" copies of dated, paid receipts, bank/credit card statements or paycheck stub and copy of your Health Club Agreement.
Weight Watcher's Location:		Confirmation form from Weight Watchers.

Certification and authorization (this form must be signed and dated below)

I authorize the release of any information to WellSense Health Plan about my health/fitness & Weight watchers club membership or health tracker purchase. I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services.

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

Please complete and mail this form (including copies of required documents) to:

WellSense Health Plan
Attn: Fitness Reimbursement
100 City Square, Suite 200
Charlestown, MA 02129

Fax: 617-897-0884
Email: IncomingMarketingMail@wellsense.org

WellSense Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla Español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-566-0012 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 888-566-0010 (TTY: 711).