TUFTS Health Plan
No one does more to keep you healthy.

Member Reimbursement Fitness Club Form

(Please print clearly, complete all sections in blue and sign. Retain a copy of all receipts and documents for your records)

1. Member's Tufts Health Plan #

2. Member's Name (Last, First, Middle Initial)

3. Member's Date of Birth / /
sex: ❑ M ❑ F

4. Member's Relationship to Subscriber
❑ Self ❑ Spouse ❑ Child ❑ Other

5. Subscriber's Name:
Address:
Telephone: ( ) -

6. Fitness Club Name:
Address:
Telephone: ( ) -

7. In what setting did the member receive treatment?
(e.g.: office, ER, hospital, clinic, ambulance, etc.)

Fitness Club

8. Outside the USA:
In what country was the member seen? _____
In what language was the bill written? _____
In what currency was the bill paid? _____

9. DIAGNOSIS: What were you seen for?

Diagnosis Code: 799 Description: General

10.

A Year of fitness club membership	B Procedure code and/or description of procedures, services, or supplies provided	C Amount paid
	* T4220 Health club membership, annual	
	*	
	*	

11. Total Amount Paid:

12. Proof of service(s) through one of the following:
❑ An itemized bill from the fitness club, listing year of membership, and dollar amounts paid

13. Proof of payment through one of the following:
❑ The front and back of the cancelled check written to the fitness club or the bank encoded front of the check written to the fitness club;
❑ A credit card statement or receipt;
❑ A statement from the fitness club, on the fitness club's letterhead with authorized signature, indicating payment was made;
❑ A receipt for purchased items, with the fitness club's name and address preprinted on the receipt, with items listed and amount paid

14. Signature is required
I attest that the above information is accurate and complete. _____

INTERNAL USE ONLY

Representative's Name/Extension: Corporate Receipt Date:

Please submit this form and all documentation to:

TUFTS HEALTH PLAN
MEMBER REIMBURSEMENT CLAIMS, PO BOX 9191
WATERTOWN, MA 02471-9191

Member Reimbursement Medical Claim Form Help Sheet
(one per member per provider)

(Please print clearly when completing the medical claim form)

FIELD #	FIELD NAME	DESCRIPTION
1	Member's Tufts Health Plan # and Plan Type	ID# with suffix, found on the front of the Tufts Health Plan ID card.
2	Member's Name	Last, First, Middle Initial of patient who received services.
3	Member's Date of Birth Member's Sex	Date of Birth: Month (2 digits), Day (2 digits), Year (4 digits) Sex: M = Male, F = Female
4	Member Relationship to Subscriber	Is the member the subscriber, the spouse, the child or an other (e.g. partner)?
5	Subscriber's Name, address, and telephone #	Subscriber is the person: ▪ who enrolls in Tufts Health Plan and signs the membership application form on behalf of him/herself and any dependents ▪ in whose name the premium is paid. Subscriber's address must include zip code. Subscriber's telephone number must include area code.
6	Provider's Name, address, telephone #, license # and state of license	Fitness club information.
7	In what setting did the member receive treatment?	Fitness club
8	Outside the USA	If applicable, indicate in what country services were provided, in what language (if not English) the bill and proof of payment are written, and in what currency the bill was paid.
9	Diagnosis: What was the member seen for?	▪ For non-mental health services, provide a procedure code or detailed description of the illness or injury.*
10A	Year of fitness club membership	The year of the fitness club membership.
10B	Procedures, Services, or Supplies Provided	▪ For non-mental health services, provide a procedure code or detailed description.* (e.g.: wig, birthing class, etc.)
10C	Amount Paid	Amount paid for fitness club membership.
11	Total Amount Paid	Total amount for which you are requesting reimbursement.
12	Proof of Service(s)	A document (see Member Reimbursement Medical Claim Form) from the fitness club listing date(s) of service, service(s) provided, and dollar amounts paid.
13	Proof of Payment	A document (see Member Reimbursement Medical Claim Form) that confirms your payment.
14	Signature is Required	SIGNATURE OF INDIVIDUAL COMPLETING FORM MUST BE INCLUDED: By signing the Member Reimbursement Medical Claim Form, you are acknowledging that services were received and paid for in the amount requested.

*As with all medical treatments, please consult with the provider office for an accurate code/description.