TUFTS Health Plan

Wellness Allowance Reimbursement Form

Use this form to request the $150 *($250 for Saver Rx)** Wellness Allowance reimbursement offered by Tufts Medicare Preferred HMO. Details on how this benefit works and what programs qualify for reimbursement can be found in Chapter 4, Section 2.1 of your EOC, available at **thpmp.org/documents**. **Reimbursement requests must be received by March 31 of the following year.**

If a Member Reimbursement is being submitted by an Authorized Representative, please complete and include the Tufts Health Plan *Appointment of Personal Representative (AOR) Form*, or any legal documentation verifying personal representation, with your request. We require verification of the authority of a Personal Representative before the request can be processed. You can find the AOR Form on our website at **thpmp.org/tmp-aor-form**.

☐ **I am completing this form as an Authorized Representative to the subscriber.**

Member Information

First name | M.I. | Last name

Date of birth | Member ID number

Service Information (Include any additional information on separate sheet)

Name of facility/class/counselor/program

Street address

City | State | ZIP

Total amount of reimbursement you are requesting

$ _____ . _____

I am requesting reimbursement for (check all boxes that apply)

- ☐ Club/facility membership fee(s)
- ☐ Nutritional counseling fee(s)
- ☐ Acupuncture
- ☐ Fitness class fee(s)
- ☐ Matter of Balance program
- ☐ Chronic disease self-management program
- ☐ Other wellness program (specify):

If you are applying your benefit toward a health club or fitness facility, please confirm you received an orientation to the facility and equipment.

- ☐ Yes, I received an orientation

Signature

I authorize the release of any information to Tufts Health Plan about my health club membership. I certify that the information provided is complete and correct and that I have not previously submitted for these services.

Signature _____ Date _____

Instructions

Reimbursement requests must be received by March 31 of the following year.

You can submit this form with paid receipts once and receive your $150 *($250 for Saver Rx)** Wellness reimbursement in full, OR you may submit this form with paid receipts several times until you have received up to $150 *($250).** You can receive up to $150 *($250)** per calendar year (January 1–December 31).

Please submit the following:

1. **This completed form** (only one member request per form please)
2. **Photocopies of one of the following:**
   - Dated, paid receipt with the name of the facility, class, or counselor preprinted on the receipt, and the amount paid
   - Front and back of cancelled check written to the facility, class, or counselor
   - Credit card statement or receipt identifying the facility, class, or counselor

Photocopies must be on 8.5″×11″ paper. Multiple receipts can be included on one page. Please keep copies of all the paperwork you send us. We are not able to return photocopies of receipts or agreements, even if the request for payment is denied.

Remember to check with your doctor before starting an exercise program!

Please mail this completed form and proofs of payment/receipts to:

Tufts Health Plan
Wellness Benefit
P.O. Box 9183
Watertown, MA 02471-9183

For more information:

Call Customer Relations at **1-800-701-9000 (TTY: 711)**
8 a.m.–8 p.m., 7 days a week (Mon.–Fri. from Apr. 1–Sept. 30).

*Members of Tufts Medicare Preferred HMO Saver Rx plan can get up to a total of $250 each calendar year.