Capital Health Plan℠
An Independent Licensee of the Blue Cross and Blue Shield Association

Health/Fitness Center Reimbursement Form

Subscribers are eligible for reimbursement once per calendar year. You must be a Capital Health Plan member and a current member of an approved health and fitness program in the calendar year. Reimbursements for the previous year cannot be processed beyond December 31 of the current year. *Beginning January 1, 2017, Federal employees, Federal Annuitants and their dependents are not eligible for this benefit.*

Capital Health Plan will reimburse only for the amount reflected on those receipts/statements up to $150 per family per CHP contract. For Medicare members, Capital Health Plan will reimburse only for the amount reflected on those receipts/statements up to $150 per member.

Section 1—Member Information *(as it appears on your CHP ID card)*

Member's Last Name _____ Member's First Name _____ Member's Middle Initial _____

Member's ID # _____
(Located on the front of your card)

Member's DOB *(mm/dd/yyyy)* _____

Member's Telephone Number _____

Note: If approved, your reimbursement will be sent to the subscriber. The subscriber is the health plan policyholder. If you need to update your address, please contact Member Services.

Section 2—Health/Fitness Center Information

Name/Address/Type of facility or activity*	Calendar Year**	Amount Requested***

* See website for facilities and programs that do not qualify.

** Calendar year is the 12-month period, beginning January 1 and ending December 31, for which reimbursement is being requested.

*** You can request up to $150 per family per Capital Health Plan contract (or member, if Medicare).

Section 3—Information for Reimbursement

Please submit each item and check off the boxes below:

- ☐ This completed form.
- ☐ Dated original receipts or copies of bank/credit statements showing the charge for membership or classes (original receipts will not be returned). These should reflect the dollar amount you are requesting. CHP will reimburse only for the amount reflected on those receipts/statements up to $150 per family per CHP contract (or member, if Medicare). *A brochure from the health club or facility may be requested in some instances.*

See reverse →

Certification and Authorization *(This form must be signed and dated below **by the member.**)*

Reimbursement subject to approval by Capital Health Plan. If approved, your reimbursement will be sent to the subscriber. The subscriber is the health plan policyholder. **Please allow 30 days from receipt for reimbursements.**

To the best of my knowledge and belief, my statements in the Health/Fitness Center Reimbursement Form are complete and true.

I am claiming reimbursement only for eligible expenses incurred during the applicable calendar year and for eligible members. I certify that these expenses have not previously been reimbursed in this or any calendar year.

Member's Signature _____ Date _____

Mail completed form to:
Capital Health Plan
Claims Department
P.O. Box 15349
Tallahassee, FL 32317-5349

Questions?

850.383.3311
or 1.877.247.6512

8:00am - 5:00pm,
Monday - Friday

Raymond Sanders
Member Services
Specialist

Medicare members, please call:
850.523.7441 or 1.877.247.6512

October 1 – March 31:
8:00am–8:00pm, seven days a week

April 1 – September 30:
8:00am–8:00pm, Monday–Friday

TTY 850.383.3534 or 1.877.870.8943

State of Florida members, please call:
1.877.392.1532, 7:00am–8:00pm, Monday - Friday

Keep copies of all documentation before sending in your Health/Fitness Center form.