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 participating member of an approved health and fitness program for at least four consecutive months in the calendar year. *Beginning January 1, 2017, Federal employees, Federal Annuitants and their dependents are not eligible for this benefit.*

Commercial Members: Reimbursement should be submitted for the current year between:

- May 1st of the current year, and
- March 31st of the following calendar year

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

Medicare Members: Reimbursement should be submitted for the current year between:

- May 1st of the current year, and
- One year from the last participation date

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

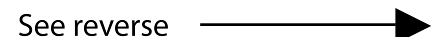
Member's ID # (located on the front of your card) | Member's Telephone number

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.

Member Services
850-383-3311 or 1-877-247-6512
8 a.m. – 5 p.m., Monday - Friday

Medicare Member Services
850-523-7441 or 1-877-247-6512
TTY 850-383-3534 or 1-877-870-8943
8 a.m. – 8 p.m., seven days a week, October 1 – February 14
8 a.m. – 8 p.m., Monday – Friday, February 15 – September 30

See reverse



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.
- ☐ A copy of any/all applicable health center contracts or agreements. These must show the beginning and ending dates of membership activity and the names of enrolled members.
- ☐ 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.

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.

Commercial Members: 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.

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

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

Member's Signature Date

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