# Fallon Senior Plan Preferred and Fallon Senior Plan Premier Preferred Reimbursement Form

As a member of a Fallon Senior Plan Preferred plan, you are eligible for reimbursement for the following services when you receive them outside of the Fallon Senior Plan Preferred network. In order to receive your reimbursement(s), please complete this form and attach the appropriate receipts for the reimbursement(s) that you are requesting. Deadline for reimbursement is one year from the date of service.

**Mail completed form to:**

Fallon Community Health Plan
Claims Department
P.O. Box 15121
Worcester, MA 01615

## Section 1—Member information

| Last name | First name | Middle initial |
|---|---|---|

Address 1

Address 2

| City | State | ZIP |
|---|---|---|

(_____)____________________
Telephone number

Member's ID # (located on the front of your Fallon Senior Plan ID card)

## Section 2 (a)—Out-of-network Weight Watchers® reimbursement

Fallon Senior Plan Preferred members can receive either the in-network or out-of-network Weight Watchers membership, but not both. Out-of-network, Fallon Senior Plan Preferred offers the maximum benefit coverage of up to $100 toward a Weight Watchers membership each calendar year. The maximum benefit coverage is the total amount that Fallon Community Health Plan will pay for a covered benefit each calendar year.* You are responsible for the difference between the amount billed for a covered benefit and the maximum benefit coverage.

**Weight Watchers facility information:**

Address

| City | State | ZIP |
|---|---|---|

Calendar year: ____________________________________________

Reimbursement amount requested: ______________________________

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

*Weight Watchers® is a registered trademark of Weight Watchers International, Inc.*

## Section 2 (b)—Out-of-network health/wellness education classes or services reimbursement (health ed classes, nutritional training and smoking cessation)

For classes or services out-of-network, Fallon Senior Plan Preferred offers the maximum benefit coverage of a doctor office visit copayment for each class or service. The maximum benefit coverage is the total amount that Fallon Community Health Plan will pay for a covered benefit. You are responsible for the remainder of the total cost for each out-of-network class/service. If you are requesting reimbursement for more than two out-of-network classes or services, please attach an additional page with the name, address, city, state, ZIP code and the reimbursement amount requested for each additional class or service.

**Health/wellness education class(es)/service(s) information:**

________________________________________
Name of class

________________________________________
Address of class

| City | State | ZIP |
|---|---|---|
| | | |

Reimbursement amount requested: ____________________

________________________________________
Name of class

________________________________________
Address of class

| City | State | ZIP |
|---|---|---|
| | | |

Reimbursement amount requested: ____________________

## Section 3—Required information for reimbursement(s)

Please submit:

- ❑ This completed form
- ❑ A dated receipt (a copy or an original), a copy of the front and the back of the canceled check or a copy of your bank/credit card statement showing the amounts you paid for:
  - Out-of-network Weight Watchers membership
  - Out-of-network health/wellness education classes or services

## Section 4—Certification and authorization

In order for this form to be complete, you must sign and date below.

Reimbursement is subject to approval by Fallon Community Health Plan. Please allow Fallon Community Health Plan 30 days from receipt for reimbursement(s). All payments will be made when we verify that the information you have provided is correct.

To the best of my knowledge and belief, my statements on this Fallon Senior Plan Preferred reimbursement form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable calendar year. I certify these expenses have not previously been reimbursed in this or any other calendar year.

______________________________________________________________________
Member's or authorized representative's name (printed)

______________________________________________________________________
Member's or authorized representative's signature

______________________
Date

If you are the authorized representative, you must supply the following information:

______________________________________________________________________
Relationship to member

______________________________________________________________________
Your address

(_____)_____________________
Your phone number