



A UnitedHealthcare Company

Gym Reimbursement Form

Oxford Health Plans Inc., P.O. Box 7082, Bridgeport, CT. 06601-7082; Phone: 1-800-444-6222

Important: Please complete this form in its entirety, or the processing of your claim may be delayed.

To be eligible for reimbursement, you must complete the information below and send the following three items to the above address:

1. This reimbursement form with 50 visits completed within a six-month period.
2. A copy of your current facility bill, showing the monthly cost of your membership.
3. A copy of the brochure that outlines the services the facility offers.

About Your Benefit:

You are eligible to receive one reimbursement per six-month period in which 50 visits are completed. The reimbursement period commences on the date of your initial visit to the gym and ends six months from that date. Subsequent reimbursement periods begin one day after your previous reimbursement period ended.

For example, if your six-month period spans from 2-10-04 to 8-10-04 and 50 visits are completed by 5-30-04, visits completed between 5-31-04 and 8-10-04 do not count towards the next six-month period. The next six-month period would begin on 8-11-04.

Your Name: _____ **Date of birth:** _____

Your Oxford Member ID Number or Social Security number: _____

Address: _____

Date of visit:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____

Date of visit:

18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____
25. _____
26. _____
27. _____
28. _____
29. _____
30. _____
31. _____
32. _____
33. _____
34. _____

Date of visit:

35. _____
36. _____
37. _____
38. _____
39. _____
40. _____
41. _____
42. _____
43. _____
44. _____
45. _____
46. _____
47. _____
48. _____
49. _____
50. _____

Name of facility: _____ **Facility employee signature:** _____

Facility employee signatures above constitutes agreement that the facility promotes cardiovascular wellness for Members. False statements will result in the denial of reimbursement.

My signature below affirms that all of the information listed above is full, complete, and true to the best of my knowledge.

Member signature: _____

Date: _____

