Fitness Reimbursement Request

Member's Name

_____

(Last Name, First Name)

ConnectiCare ID #

_____

Insured's Name

_____

(Last Name, First Name)

Insured's Address

_____

No. Street

_____

City *State*

_____(_____)_____

Zip Code *Telephone Number*

Patient's Relationship to Insured Self Spouse Child Other

Date(s) of Service ☐ ☐ ☐ ☐

_____

Health Club Name _____

Health Club Address

_____

No. Street

_____

City State

_____ (_____)_____

Zip Code *Telephone Number*

Total Amount Submitted: $

_____

Certification and Authorization (This form must be signed and dated below.)
I authorize the release of any information to ConnectiCare of Massachusetts, Inc. about my health club membership. I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services.

Insured's/Member's Signature_____ **Date:** _____

Send this completed form AND required documentation to:
ConnectiCare of Massachusetts, Inc.
Attn: Fitness Benefit
PO Box 522
Farmington, Connecticut 06034-0522

The required documentation must include a copy of the health club contract that includes the name and address of the health club along with the membership dates.

ConnectiCare