



Oxford Health Plans®

# Gym Reimbursement Form

Oxford Health Plans Inc., P.O. Box 7082, Bridgeport, CT. 06601-7082; Phone: 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:** \_\_\_\_\_ **Your Member ID Number:** \_\_\_\_\_

**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:** \_\_\_\_\_