



## BIKE HELMET REIMBURSEMENT REQUEST

Subscriber's Name: \_\_\_\_\_

Subscriber's Member ID Number \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone # \_\_\_\_\_ Mobile/Cell # \_\_\_\_\_

### Reimbursement Request Details

Member's Name: \_\_\_\_\_

\*Calendar Year \_\_\_\_\_ Requested Amount \_\_\_\_\_

Member's Name: \_\_\_\_\_

\*Calendar Year \_\_\_\_\_ Requested Amount \_\_\_\_\_

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

### Certification/Authorization

To the best of my knowledge and belief, my statements in this Reimbursement Request Form are complete and true. I am claiming reimbursement only for eligible expenses and for eligible members incurred during the applicable calendar year. I certify that these expenses have not been previously reimbursed in this or any other calendar year.

Subscriber's Signature \_\_\_\_\_ Date \_\_\_\_\_



## BIKE HELMET REIMBURSEMENT ELIGIBILITY GUIDELINES

- AllWays Health Partners members are eligible for reimbursement of the purchase price of one (1) new helmet up to \$15.00 per member, per calendar year.
- Check will be made payable to the Subscriber of the policy.
- **To be eligible for reimbursement, requests must be made by March 31 of the following calendar year.**
- Reimbursement requests are subject to approval by AllWays Health Partners.
- Please allow 30 business days for processing.

### Reimbursement Request Checklist

To request reimbursement for your qualifying bike helmet (s), be sure to submit the following items:

- This completed form
- Dated, original receipt(s)

**Important:** Please make copies for your records of original receipts and any other documents being submitted with your reimbursement request. AllWays Health Partners cannot return these, even for denied requests.

**For your convenience, you may submit your request by mail or fax as follows:**

**Mail:**

AllWays Health Partners  
Claims Department  
399 Revolution Drive – Suite 940  
Somerville, MA 02145

**Fax:**

AllWays Health Partners  
Claims Department  
617-526-1902