allways[sm]
HEALTH PARTNERS

Weight Loss Program Benefit
Form & Instructions

What is my weight loss program benefit?

Your weight loss benefit rewards you or someone in your family for losing weight the healthy way. If you qualify, you can be reimbursed for up to six months of membership fees at Weight Watchers (WW) or Jenny Craig. To see if your plan includes the benefit, and if you or a family member qualifies, check your Schedule of Benefits at **allwaysmember.org**.

How do I get reimbursement for the full six months?

To get the full value from this benefit, wait until you have been a member of AllWays Health Partners and WW or Jenny Craig for a full 6 months. Why? You can only request your weight loss benefit one time per calendar year. You have until March 31 of the following year to submit your Weight Loss Program Benefit Form.

How do I request reimbursement for my weight loss benefit?

There are two ways to submit your request form:

SUBMIT ON OUR MEMBER PORTAL

The most convenient way to request your reimbursement is on **allwaysmember.org**:

- Complete your form online
- Get confirmation of your submission right away
- Track the progress of your request

Please allow 30 days for processing

SUBMIT BY MAIL

Fill out the form on the back of this flyer, and mail it to:

AllWays Health Partners
Attention: Claims/Fitness
399 Revolution Drive Suite 940
Somerville MA 02145

You will not get confirmation of your request.
Please allow 60 days for processing.

You can also fax your request form to **617-526-1902**.

Please note:

- The weight loss program benefit does not cover food, nutritional supplements, or enrollment/registration fees.
- The deadline to request your weight-loss benefit for each calendar year is March 31 of the following year. You can only submit one request per calendar year.
- We reserve the right to randomly audit requests for eligibility. If you are chosen for audit, we will contact you and request additional documentation. The audit will take an additional 14 days to process upon receipt of complete documentation.

Continued

Weight Loss Program Benefit
Coverage Request Form

Subscriber Information (The subscriber is the primary insurance policyholder.)

LAST NAME | FIRST NAME | M.I.

STREET ADDRESS | CITY | STATE | ZIP

TELEPHONE NUMBER | MEMBER ID# (located on the front of the AllWays Health Partners ID card)

Weight Loss Program Information (Please check one.) ☐ Jenny Craig ☐ WW

Payment Information

Calendar year reimbursement being requested: _____

Check off months of membership in a qualified weight loss program

☐ January ☐ February ☐ March ☐ April ☐ May ☐ June ☐ July ☐ August ☐ September ☐ October ☐ November ☐ December

Weight loss program fee per month: _____

Certification/Authorization

The subscriber must sign and date below. The weight loss program benefit is subject to approval by AllWays Health Partners. Please note: the check will be made payable to the health plan's subscriber.

Reimbursement requested for:

(Please check one.) ☐ SUBSCRIBER ☐ COVERED DEPENDENT

Below, please print the full name of the covered dependent who is requesting the weight loss program benefit (if other than the subscriber).

_____

To the best of my knowledge and belief, my statements on this form are complete and true.
I am claiming reimbursement for the coverage allowed as indicated in my Schedule of Benefits.

_____

ALLWAYS HEALTH PARTNERS SUBSCRIBER'S SIGNATURE | DATE