Mass General Brigham
Health Plan

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 in a qualified weight-loss program. To see if your plan includes the benefit, check your Schedule of Benefits and the list of qualified weight-loss programs at **Member.MassGeneralBrighamHealthPlan.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 Mass General Brigham Health Plan in a qualified weight-loss program 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 ways to request your reimbursement are on our member portal or in the Mass General Brigham Health Plan Member app:

- Complete your form online
- Get confirmation of your submission right away

Please allow 15-30 days for processing

Submit by mail

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

Mass General Brigham Health Plan
Attention: Claims/Fitness
399 Revolution Drive Suite 940
Somerville MA 02145

You will not get confirmation of your request. Please allow 30-45 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.

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 Mass General Brigham Health Plan ID card)	

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

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 Mass General Brigham Health Plan. 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.

_____

MASS GENERAL BRIGHAM HEALTH PLAN MEMBER'S SIGNATURE DATE