A UnitedHealthcare Company

Gym Reimbursement Form

Oxford Health Plans Inc., P.O. Box 7082, Bridgeport, CT. 06601-7082; Phone: 1-800-444-6222

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 2-10-05 to 8-10-05 and 50 visits are completed by 5-30-05, visits completed between 5-31-05 and 8-10-05 do not count towards the next six-month period. The next six-month period would begin on 8-11-05.

Your Name: ____

Your Oxford Member ID Number: ______________________________

Address: ____

Date of visit:	Date of visit:	Date of visit:
1. ______	18. ______	35. ______
2. ______	19. ______	36. ______
3. ______	20. ______	37. ______
4. ______	21. ______	38. ______
5. ______	22. ______	39. ______
6. ______	23. ______	40. ______
7. ______	24. ______	41. ______
8. ______	25. ______	42. ______
9. ______	26. ______	43. ______
10. ______	27. ______	44. ______
11. ______	28. ______	45. ______
12. ______	29. ______	46. ______
13. ______	30. ______	47. ______
14. ______	31. ______	48. ______
15. ______	32. ______	49. ______
16. ______	33. ______	50. ______
17. ______	34. ______	

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:** ______________________