EmblemHealth®

Health Club Reimbursement Form

Please complete all of the information requested below. Remember to attach a copy of your membership contract from the facility as well as your current health club facility bill showing the cost of your membership* and proof of payment (receipts, cancelled checks). Submit this form and other material to the address below:

EmblemHealth
JAF Station PO Box 2884
New York, NY 10116

MEMBER INFORMATION:

Last name	First name	Middle initial
HIPID #	Member date of birth (mm/dd/yy)	

Name and address of health club facility where you are an active member:

Name of health club		
Street address		
City	State	ZIP
Date of membership: From (mm/dd/yy) _____ To (mm/dd/yy) _____		
Total annual membership fee:	Total amount paid by member:	Date of final payment:

*Annual membership fees excludeinitiation fees paid to facility. Reimbursement by EmblemHealth will be made once the entire annual membership is paid in full. No proof of installment payments should be submitted to EmblemHealth unless the total amount of all installments paid is equal to the annual membership cost. EmblemHealth will not reimburse members on an installment basis. Annual membership is defined as a 12 consecutive month period with no interruptions. Reimbursement may need to be prorated based on the portion of the year members are enrolled in a health benefits plan with this covered benefit.

FOR INTERNAL USE ONLY:

Cptcode: GYM12	POS: 99 Provider	Lic: MEMREIMNY 001	Prov TIN: MEMREIMNY 000IC	ICD9: V690