WEIGHT WATCHERS REIMBURSEMENT

Effective January 1, 2019 through December 31, 2019

During 2019, Tufts University will provide a Weight Watchers® reimbursement to employees who are enrolled in a Tufts University health plan.

Qualifying Weight Watchers programs include:

- Traditional Weight Watchers meetings
- Weight Watchers At Work program

Please note that the Weight Watchers Online and Weight Watchers At Home programs do not qualify. In addition, fees for individual nutrition counseling sessions, food, books, videos, scales, or other items do not qualify for the reimbursement.

The reimbursement is available to members age 13 and older. The subscriber and one other covered dependent qualify for a $150 individual reimbursement with a maximum of $300 per family, per calendar year, paid to the subscriber. To be eligible, members must be enrolled in a Tufts University health plan for at least 3 months during 2019.

To receive the reimbursement, once you have enrolled and paid for a qualifying program, mail a copy of your receipt and the reimbursement form (on the reverse of this page) to Tufts Health Plan.

For more information about the Weight Watchers reward, please contact Tufts Health Plan Member Services at 844.516.5790.

SUBMIT YOUR REIMBURSEMENT FORM

tuftshealthplan.com/tuftsuniversity | 844.516.5790

TU-WEIGHT-6/18
WEIGHT WATCHERS REIMBURSEMENT FORM – 2019

You must complete all fields. Please print clearly. Retain a copy of all receipts and documents for your records. Please be sure to sign the form. Tufts University employees who have been a health plan member for at least three months during 2019 are eligible.

You have until March 31, 2020 to submit your request for the Weight Watchers reimbursement for 2019. The reimbursement applies to the subscriber and to one dependent age 13 or older per year. It is paid to the Tufts Health Plan subscriber. Tufts Health Plan usually process reimbursements within 4 to 6 weeks of receipt.

SUBSCRIBER INFORMATION (If a reimbursement is being requested for the subscriber)

Name (Last, First, Middle Initial): ________________________________________________________________

Date of Birth: _____ / _____ / _______ Sex: ☐ M ☐ F

TUFTS HEALTH PLAN ID# ___________ ___________ ___________ ___________ ___________ ___________ ___________ ___________ 

Address: __________________________________________________________________________________________

Telephone: __________________________________________________________________________________________

WEIGHT WATCHERS INFORMATION

Location Name: ___________________________ Telephone: ___________________________

Address: __________________________________________________________________________________________

PAYMENT INFORMATION

Please indicate which one of the following forms of proof of payment you are including with this form:

☐ The front and back of the cancelled check written to the Weight Watchers program or the bank-encoded front of the check written to the Weight Watchers program

☐ A statement from the Weight Watchers program, on the program’s letterhead with an authorized signature, indicating payment

DEPENDENT INFORMATION (If a reimbursement is being requested for a family member)

Name (Last, First, Middle Initial): ________________________________________________________________

Date of Birth: _____ / _____ / _______ Sex: ☐ M ☐ F Tufts Health Plan ID# ___________ ___________ ___________ ___________ ___________ ___________ ___________ ___________ 

Address: __________________________________________________________________________________________

Telephone: __________________________________________________________________________________________

WEIGHT WATCHERS INFORMATION

Location Name: ___________________________ Telephone: ___________________________

Address: __________________________________________________________________________________________

PAYMENT INFORMATION

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FOR INTERNAL USE ONLY

Diagnosis Code: 799 Description: General Procedure code: S9449 Weight management class, non-physician

SIGNATURE REQUIRED

I attest that the above information is true and accurate, and the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent, my coverage may be canceled and I may be subject to criminal and/or civil penalties for false health care claims. I also understand that Tufts Health Plan may request any additional information it deems necessary to verify that services were received and payment was made. I understand that this reimbursement may be considered taxable income.

Subscriber Signature: (If applicable) __________________________________________________________ Date: _________________

Dependent Signature: (If applicable) ___________________________________________________________ Date: _________________

Please submit this form and all documentation to:

Tufts Health Plan  |  Member Reimbursement Claims, PO Box 9191
Watertown, MA 02471-9191

Please do not staple any materials to this form