Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

PLEASE REVIEW AND LEGIBLY COMPLETE ALL SECTIONS (1-4) OF THIS FORM

Please Note: COPIES OF ALL BILLS/RECEIPTS MUST BE SUBMITTED WITH THIS FORM IN ORDER FOR YOUR REWARD TO BE CONSIDERED. If you do not have a valid bill/receipt, please contact the provider of service to obtain prior to submitting your reward reimbursement. NOTE: Please submit one rewards request per College Reward Request form. Separate reward requests need to be submitted for each qualified reward request according to your contract. To be eligible for the reward benefit services must be for one of the qualified expenses listed below.

If you have eligibility, benefit or form related questions, please contact customer service using the number listed on the back of your member ID card.

BlueHealthy Dollars Reimbursement Form

Mail completed form and all required information to:

P.O. Box 21146
Eagan, MN 55121-0146

SECTION 1
INFORMATION REQUIRED FOR REIMBURSEMENT

COPIES OF ALL BILLS/RECEIPTS FOR QUALIFIED EXPENSES **MUST BE SUBMITTED** WITH THIS FORM IN ORDER FOR REIMBURSEMENT TO BE CONSIDERED. BALANCE BILL, CANCELED CHECKS ETC. ARE **NOT** ACCEPTABLE. BILLS MUST *CLEARLY* INDICATE **ALL OF THE FOLLOWING**:

1. FULL NAME AND DATE OF BIRTH OF THE PERSON RECEIVING SERVICES
2. NAME AND ADDRESS OF THE INDIVIDUAL OR BUSINESS/ORGANIZATION PROVIDING THE SERVICE(S)
3. DATE FOR SERVICE RENDERED
4. CHARGE FOR SERVICE RENDERED
5. ALL CLAIMS FOR REIMBURSEMENT MUST BE SUBMITTED WITHIN 12 MONTHS FROM THE DATE SERVICES WERE RENDERED IN ORDER TO BE CONSIDERED FOR PAYMENT.

SECTION 2
SUBSCRIBER INFORMATION

Please enter all information exactly as shown on your ID card

SUBSCRIBER'S LAST NAME	SUBSCRIBER'S FIRST NAME	SUBSCRIBER IDENTIFICATION NUMBER

ADDRESS-NUMBER AND STREET	CITY	STATE	ZIP CODE

2i-PATIENT'S LAST NAME	2j-FIRST NAME	2k-INITIAL	2L-DATE OF BIRTH	2m-GENDER	2n-PATIENT'S RELATIONSHIP TO SUBSCRIBER
			_____/_____/_____ mm dd yyyy	M F	Self Child Spouse

DATE(S) OF SERVICE	SERVICE INFORMATION	AMOUNT
From: ____ / ____ / _____ *mm dd yyyy*	☐ HEALTH RELATED CLASSES FOR ADULTS S9451/Dx. Z7189 ☐ WEIGHT MANAGEMENT PROGRAMS S9449/Dx. Z7189 ☐ HEALTH CLUB/GYM MEMBERSHIP S9446/Dx. Z7189 ☐ MASSAGE THERAPY 97124/Dx. Z7189 ☐ TOBACCO CESSATION 99406, 99407, OR G0436/Dx. Z7189 ☐ ON LINE SUBSCRIPTIONS S9446/Dx. Z7189 ☐ AT HOME FITNESS EQUIPMENT S9446/Dx. Z7189	$ _____
PROVIDED BY:		

PLEASE NOTE: DO NOT ENTER ANY ADDITIONAL INFORMATION IN ANY OF THE BOXES ON THIS FORM

SECTION 3
SIGNATURE AND DATE

Unsigned forms will be returned

I CERTIFY THAT THE INFORMATION SUBMITTED IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. THE EXPENSES INCURRED WERE FOR MYSELF, SPOUSE, OR QUALIFIED DEPENDENT(S), AND THAT THESE EXPENSES ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE.

SUBSCRIBER SIGNATURE: _____ **DATE:** _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals information concerning any fact material thereto, for the purpose of misleading, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of each violation.

BlueHealthy Dollars Reimbursement Form Instructions

Please Note: COPIES OF ALL BILLS/RECEIPTS MUST BE SUBMITTED WITH THIS FORM IN ORDER FOR YOUR REWARD TO BE CONSIDERED. If you do not have a valid bill or receipt, please contact the provider of service to obtain prior to submitting for your reward reimbursement.

NOTE: Please submit one rewards request per reward request form. Separate reward requests need to be submitted for each qualified reward request according to your contract. To be eligible for this reward benefit services must be for one of the qualified expenses listed below.

If you have eligibility, benefit or form related questions, please contact customer service using the number listed on the back of your member ID card.

1) **SECTION 1: INFORMATION REQUIRED FOR REWARD**

COPIES OF ALL BILLS/RECEIPTS FOR QUALIFIED EXPENSES **MUST BE SUBMTTED** WITH THIS FORM IN ORDER FOR YOUR REWARD TO BE CONSIDERED. BALANCE BILL, CANCELLED CHECKS ETC. ARE **NOT** ACCEPTABLE. BILLS MUST ***CLEARLY*** INDICATE **ALL OF THE FOLLOWING:**

1 – FULL SUBSCRIBER NAME

2 – NAME AND ADDRESS OF INDIVIDUAL OR BUSINESS/ORGANIZATION PROVIDING THE SERVICE

3 – NAME OF MEMBER WHO RECEIVED THE SERVICE

3 – DATE SERVICE WAS RENDERED

4 – CHARGE FOR SERVICE RENDERED

5 – ALL REWARD REQUESTS MUST BE SUBMITTED WITHIN **365 DAYS** AFTER SERVICE WAS PROVIDED IN ORDER TO BE CONSIDERED FOR REWARDS PAYMENT

2) **Section 2**

Subscriber Information (Please enter all information exactly as shown on your ID Card)

SUBSCRIBERS'S LAST NAME: Last Name of the Subscriber

SUBSCRIBER'S FIRST NAME: First Name of the Subscriber

SUBSCRIBER IDENTIFICATION NUMBER: Subscriber ID as it appears on your card

ADDRESS NUMBER AND STREET: Subscriber home address – please include apartment number if applicable

CITY: City in which your home address resides

STATE: State in which your home address resides

ZIP CODE: Zip Code in which your home address resides

Patient's Last Name: Last Name of member who is receiving the service

First Name: First name of member who is receiving the service

Date of Birth: Date of birth for the member receiving the service in a mm/dd/yyyy format

Gender: Gender of member receiving the service

Patient Relationship to the Subscriber: Relationship of member to the Subscriber

In this next section: Please complete all sections below for the individual QUALIFIED service rendered. **Individual reward requests need to be submitted for each eligible QUALIFIED service according to your contract. If you do not know your benefit, you can check your benefit by logging into www.excellusbcbs.com Click on My Account from the main menu and then click on View Health and Wellness. Search for "BlueHealthy Dollar Rewards". Or you can call the phone number listed on the back of your ID Card.**

DATE of SERVICE: Date the service was provided

SERVICE INFORMATION: Select only ONE provided service per claim form

REWARD AMOUNT: Enter in the dollar value for reward you are requesting. This amount must match what it included on your bill/receipt that you are attaching.

Provided By: Enter the name of the Individual, Business or Organization providing the service

PLEASE NOTE: DO NOT ENTER ANY ADDITIONAL INFORMATION IN ANY OF THE BOXES ON THIS FORM

3) **SECTION 3**

Please verify that all the information above is printed clearly and all of the boxes are appropriately filled out. Once confirmed, please sign and date in the designated section

Mail Completed Form to:
P.O. Box 21146
Eagan, MN 55151-0146