Exercise Facility Reimbursement Form

Oxford Health Plans • P.O. Box 7082 • Bridgeport, CT 06601-7082

To be eligible for reimbursement, you must complete the information below and send the following three items to the above address.

1. **This Exercise Facility 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 facility brochure outlining the services they provide.**

Last name (Subscriber): ______________________ First name & MI:______________________

Spouse's last name: ______________________ First name & MI:______________________

Subscriber's ID Card number:______________________ Subscriber's DOB (m/d/y):_____/_____/_____

Spouse's ID Card number: ______________________ Spouse's DOB (m/d/y):_____/_____/_____

Name of facilty where you are an active member:______________________________

Address of facilty:______________________________

Date of Visit	Signature of Facility Representative	Date of Visit	Signature of Facility Representative	Date of Visit	Signature of Facility Representative
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		32		50	
17		34			

Phone ______________________ Fax ______________________

Facility employee signatures above constitute agreement that the facility promotes cardiovascular wellness for Members.
False statements will result in a denial of coverage.
My signature below affirms that all of the information listed above is full, complete, and true ,to the best of my knowledge.

______________________________ ______________________

Employee/Applicant Signature Date