



Oxford Health Plans®

Exercise Facility Reimbursement Form

Oxford Health Plans • P.O. Box 7081 • Bridgeport, CT 06601-7085

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 facility where you are an active member: _____

Address of facility: _____

Table with 6 columns: Date of Visit, Signature of Facility Representative, Date of Visit, Signature of Facility Representative, Date of Visit, Signature of Facility Representative. Rows 1-50.

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