



For Health Plan Use

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 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.

Wellness & Rewards Reimbursement Form

Mail completed form and all required information to:

P.O. Box 21494
Eagan, MN 55121-0494

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
MEMBER'S LAST NAME	FIRST NAME	INITIAL	DATE OF BIRTH ____/____/____ mm dd yyyy	GENDER ☐ M ☐ F ☐ X	MEMBER'S RELATIONSHIP TO SUBSCRIBER ☐ Self ☐ Child ☐ Spouse ☐ Other
DATE(S) OF SERVICE	SERVICE INFORMATION			AMOUNT	
From: ____/____/____ mm dd yyyy	☐ FITNESS CENTER/GYM MEMBERSHIP (including youth sports) S9970 / Dx. Z7189 ☐ WEARABLE FITNESS DEVICE A9300/Dx. Z7189 ☐ CHILDBIRTH/PARENTING PROGRAMS S9446 / Dx. Z7189 ☐ WEIGHT MANAGEMENT PROGRAMS S9449 / Dx. Z7189 ☐ LASIK S0800 / Dx. Z7189 ☐ DOULA SERVICE(S) T1033 / Dx. Z7189 ☐ MYFITRX / KIDS ON THE MOVE (CICCOTTI CENTER) 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.

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.

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

Copies of all bills/receipts for qualified expenses **must be submitted** 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:**

- Full subscriber name
- Name and address if individual or business/organization providing the service
- Name of member who received the service
- Date service was rendered
- Charge for service rendered
- All reward requests must be submitted within 365 days after service was provided in order to be considered for rewards payment

- **SECTION 2**

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

Subscriber's last name: Last name of the subscriber

Subscriber's first name: First name of the subscriber

Subscriber's ID 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

Member'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.

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

Individual reward requests need to be submitted for each eligible QUALIFIED service according to your contract.

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 21494

Eagan, MN 55151-0494

FREQUENTLY ASKED QUESTIONS

Eligible subscribers can be reimbursed up to \$400 per plan year for qualified fitness activities, and their covered dependents can earn a combined \$200 – a total of \$600 per contract! To determine if you have this benefit, log in to your member account at **www.cdphp.com/wellness-services** and look for “Fitness Reimbursement” in the Your Coverage box or you can also call the number on your ID card to confirm eligibility.

What qualifies?

- Gym fees, paid fitness classes, paid digital fitness classes, and parent and baby fitness classes.
- The dependent portion can be used for youth sports fees for members under age 18.
- Wearable fitness devices. Please note there is a cap on how much of your reimbursement amount can be used for qualified devices. Subscribers can be reimbursed up to \$200 for qualified devices (out of the \$400 maximum) and covered dependents can be reimbursed up to a combined \$100 for qualified devices (out of the \$200 maximum).

Who is eligible for this benefit?

- Subscribers and covered dependents of fully insured commercial plans.
- Eligibility varies for members of self-insured plans.

I do have this benefit. Now, how do I qualify and submit for reimbursement?

- Visit the gym/fitness facility or attend a digital fitness class at least 50 times to qualify for reimbursement.
- Keep your receipts from qualified activities or for qualified devices.
- Submit for reimbursement online by logging in at **member.cdphp.com** and clicking the Health & Wellness tab, or complete the paper form.
- Parent and baby classes should be submitted under the dependent’s name.
- You should apply for reimbursement within 12 months of the end of your plan year.
- Please allow 30 days for your submission to be processed and payment to be sent via mail.

What qualifies for Fitness Reimbursement?

- A gym or exercise center that houses traditional exercise equipment and is open to the general public
- Virtual or online fitness program subscriptions that include digital fitness classes (Peloton, BODi, etc.).
- Specialty fitness studios (i.e. yoga, barre, indoor cycling, and other fitness studios).
- Parent and baby fitness classes (yoga, swim lessons, etc.)
- Wearable fitness devices such as an Apple Watch or Fitbit.
- Sports activities for dependents under age 18 (soccer club fees, youth rugby, gymnastics, etc.).

What expenses qualify for reimbursement?

- Annual membership fees paid for qualifying gyms.
- Monthly or annual subscription fees paid for virtual or online fitness classes and at home workouts.
- Fees paid for individual classes or a package of classes at specialty fitness studios.
- Fees paid for sports activities for dependents under the age of 18.
- Fees paid for parent and baby fitness classes.
- Funds used for the purchase of qualified wearable fitness devices.

Membership fees for country clubs, weight loss clinics, spas, or other similar facilities do not qualify for reimbursement. Fitness equipment is not eligible for reimbursement.