



Oxford Health Plans®

### 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 facility where you are an active member: \_\_\_\_\_

Address of facility: \_\_\_\_\_

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