Health/Fitness Center Reimbursement Form

Subscribers are eligible for reimbursement once per calendar year.
Requests must be made no later than March 31 of the following calendar year.

Section 1—Subscriber Information (as it appears on your CHP ID card)

(Note: The subscriber is the health plan policyholder.)

Subscriber's last name | First name | Middle initial

Address | City | State | ZIP

Subscriber's ID # (located on the front of your card) | ( ) Telephone number

Section 2—Health/Fitness Center Information

Name/Address/Type of facility or activity	Calendar year*	Amount requested**

* Calendar year is the 12-month period, beginning January 1 and ending December 31, for which reimbursement is being requested.

** You can request up to $150 per family per CHP contract.

Section 3—Information for Reimbursement

Please submit each item and check off the boxes below:

- ☐ This completed form.
- ☐ A copy of any/all applicable health center contracts or agreements. These must show the beginning and ending dates of membership activity and the names of enrolled members.
- ☐ Dated original receipts or copies of bank/credit statements showing the charge for membership or classes (original receipts will not be returned). These should reflect the dollar amount you are requesting. CHP will reimburse only for the amount reflected on those receipts/statements up to $150 per family per CHP contract.

A brochure from the health club or facility may be requested in some instances.

Certification and Authorization (This form must be signed and dated below **by the subscriber**)

Reimbursement subject to approval by Capital Health Plan. All payments will be made with subscriber's authorization. Subscriber's signature required. Please allow 30 days from receipt for reimbursements.

To the best of my knowledge and belief, my statements in the Health/Fitness Center Reimbursement Form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable calendar year and for eligible members. I certify that these expenses have not previously been reimbursed in this or any calendar year.

Subscriber's signature | Date

Plan features may vary.

Mail completed form to:
Capital Health Plan
Claims Department
P.O. Box 15349
Tallahassee, FL 32317-5349

Keep copies of all documentation before sending in your Health/Fitness Center form.

2007.16.Fitness.Form