CareConnect℠

Gym Reimbursement Form

We make it easy for you to get and stay healthy—and one way we do that is by helping you pay for your fitness center, health club or gym membership. We'll reimburse you up to $200 every six months for membership in a fitness center that maintains cardio equipment and offers programs that promote cardiovascular wellness, or for attendance at exercise classes such as yoga, pilates and spinning. To qualify for the reimbursement, you must visit the gym or attend class at least 50 times in the six-month period. You could get a check for $400 each year!*

IMPORTANT DETAILS:

- Your fitness facility must provide at least two pieces of equipment that promote cardiovascular health.
- You must complete at least 50 visits in a six-month period. We cannot issue a reimbursement until a six-month period is complete, even if you complete the 50 visits more quickly than that.
- Once you've completed a six-month reimbursement period, you'll need to fill out our reimbursement form. You'll also need a copy of your current gym bill; proof of payment (a receipt, a copy of your credit card statement, etc.); and a record of your gym visits (a printout from your gym or a list that includes the dates of your visits and is signed by a representative of the gym). If you want to create a written list of your visits, please use the form on page 2.
- Children of the insured are not eligible for any reimbursement.
- Just send the above material and completed form to: CareConnect
  Attn: Member Reimbursement
  P.O. Box 830259,
  Birmingham, AL 35283

Note: Materials must be complete and submitted within six months of the end of the reimbursement period to qualify for payment.

Please complete this form in full, or your claim may be delayed or denied. Complete one form per member for each six-month period for which you're making a claim.

* Children are not eligible for reimbursement.

For any questions, please call CareConnect Customer Service at 855-706-7545 or email info@nslijcc.com

MEMBER INFORMATION

Last name | First name | Middle initial

Member ID# | Member birth date (mm/dd/yy)

Street Address | City | State | Zip

Patient Name (if different from member) | Patient birth date (mm/dd/yy) | Phone

SERVICE INFORMATION

Start Date	End Date	Place of Service	Code for procedures, services, or supplies	Diagnosis Code	Charges	Number of Visits	Provider ID
/ /	/ /	99	S5190	V65.41			???????

CareConnect Manager Signature | CareConnect Manager Name (print)

(Continued)

Gym Reimbursement Form (continued)

YOUR FITNESS FACILITY

Name of Facility

Street Address City State Zip

Membership fee paid by member: $_____ Membership fee paid : ☐ Monthly ☐ Annually

DATE	DATE	DATE	DATE
1	16	31	46
2	17	32	47
3	18	33	48
4	19	34	49
5	20	35	50
6	21	36	51
7	22	37	52
8	23	38	53
9	24	39	54
10	25	40	55
11	26	41	56
12	27	42	57
13	28	43	58
14	29	44	59
15	30	45	60

Gym Representative Signature Gym Representative Name (print)