



Today's date ___/___/___

Please complete this form and attach an original receipt so we can pay you back. We keep the information you list below on record. You must be a member at time of purchase and when we process this form. We can't process reimbursements if you don't complete this form. You can use this form for more than one reimbursement. You should get your reimbursement in 4 – 6 weeks.

Member information

Member name _____ Member ID # _____ DOB ___/___/___

Member address _____ E-mail address _____

Member phone _____ - _____ - _____ Member alternate phone _____ - _____ - _____

Primary care provider (PCP) information

PCP name _____

PCP address _____

Please check the Network Health EXTRAS you want us to reimburse

- Weight Watchers (up to \$50 reimbursement per year)
- Gym membership or fitness-related activity (up to \$50 reimbursement per year)
- Acupuncture services (up to \$150 reimbursement per year)
- Childbirth/Newborn/Breastfeeding classes (up to \$150 reimbursement per year)

Network Health should make the check payable to _____

Please attach
original receipt(s).

Please submit this form to:
Network Health
Attn: Customer Service
101 Station Landing, Fourth Floor
Medford, MA 02155

Or fax to: 781-393-3530

Questions? Call us at 888-257-1985.