



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