Excellus
165 Court Street
Rochester, NY 14647

A nonprofit independent licensee of the BlueCross BlueShield Association

SimplyBlue

Lifestyle Benefits Reimbursement Form

	Subscriber ID Number
Subscriber's Full Name	**Employer**
Address	**Telephone Number**
City, State Zip Code	**Please Note:** If your address has changed or is incorrect, please call our Customer Service Department at the telephone number listed on your identification card.

Lifestyle Benefits:

☐ **Health Club Membership**

Instructions on reverse side **IMPORTANT: SIGNATURE REQUIRED BELOW**

I certify the information here is true and correct, that the expenses incurred were for myself, spouse, or qualified dependents, and that these expenses are not reimbursable under any other health plan coverage. Unsigned forms will be returned.

Date: **Subscriber Signature:**

Patient Name	**Relationship to Subscriber** SELF/SPOUSE/CHILD/ OTHER (SPECIFY)	**Amount**	**Date(s) of Service**	**Description of Service**	**Does This Patient Have Insurance Coverage For This Service?** (Y/N)	**Provider Name**

INSTRUCTIONS

1. Copies of **all bills/receipts** for reimbursement must be enclosed with this completed reimbursement form.

   Bills must include:
   - Name of person providing the service
   - Dates of service
   - Description of the service(s) rendered
   - The amount charged
   - The name of the person receiving services

   Balance bill, cancelled checks, etc. are **not** acceptable.

2. A Lifestyle Benefits Reimbursement from must be submitted within 12 months after the member received the service in order to be considered for payment from us.

3. Please **sign** this reimbursement form.

4. Mail completed reimbursement form to:

   P.O. Box 21146
   Eagan, MN 55121

If you have any questions, please call our Customer Service Department at the number listed on your identification card.