CarePartners of Connecticut MEDICARE ADVANTAGE

2024 Wellness Allowance Reimbursement Form

Use this form to request the $175 Wellness Allowance reimbursement available to CarePartners of Connecticut CareAdvantage Preferred HMO members. Details on how this benefit works and what programs qualify for reimbursement can be found on page 77-78 of your EOC, available at **carepartnersct.com/2024-hmo-preferred-eoc**. **Reimbursement requests must be received by March 31 of the following year.**

If a Member Reimbursement Form is being submitted by an Authorized Representative, please complete and include the CarePartners of Connecticut *Appointment of Personal Representative (AOR) Form*, or any legal documentation verifying personal representation, with your request. We require verification of the authority of an Authorized Representative before the request can be processed. You can find the AOR Form on our website at **carepartnersct.com/aor**.

☐ **I am completing this form as an Authorized Representative to the subscriber.**

Member Information

First name | M.I. | Last name

Date of birth | Member ID number

Service Information (Include any additional information on separate sheet)

Name of facility/class/counselor/program

Street address

City | State | ZIP

Total amount of reimbursement you are requesting

$ _____ . _____

I am requesting reimbursement for (check all boxes that apply)

- ☐ Club/facility membership fee(s)
- ☐ Nutritional counseling fee(s)
- ☐ Fitness class fee(s)
- ☐ Matter of Balance program
- ☐ Chronic disease self-management program
- ☐ Memory fitness
- ☐ Activity tracker[1]
- ☐ Other wellness program (specify):

Signature

I authorize the release of any information to CarePartners of Connecticut about my health club membership. I certify that the information provided is complete and correct, and that I have not previously submitted for these services.

Signature _____ Date _____

Instructions

Reimbursement requests must be received by March 31 of the following year. Reimbursement requests submitted for plans other than CareAdvantage Preferred HMO cannot be accepted by the plan.

You can submit this form with paid receipts once and receive your $175 Wellness reimbursement in full, OR you may submit this form with paid receipts several times until you have received up to $175. You can receive up to $175 per calendar year (January 1–December 31).

Please submit the following:

1. **This completed form** (only one member request per form, please)
2. **Photocopies of one of the following:**
   - Dated, paid receipt with the name of the facility, class, or counselor preprinted on the receipt, and the amount paid
   - Front and back of cancelled check written to the facility, class, or counselor
   - Credit card statement or receipt identifying the facility, class, or counselor

Photocopies must be on 8.5″×11″ paper. Multiple receipts can be included on one page. Please keep copies of all the paperwork you send us. We are not able to return photocopies of receipts or agreements, even if the request for payment is denied.

Remember to check with your doctor before starting an exercise program!

Please mail this completed form and proofs of payment/receipts to:

CarePartners of Connecticut
Attn: Member Reimbursement
P.O. Box 518
Canton, MA 02021-0518

For more information:

Call Member Services at **1-888-341-1507 (TTY: 711)**
8 a.m.–8 p.m., 7 days a week (Mon.–Fri. from Apr. 1–Sept. 30).

[1]Available once every 3 years.