Flex Benefit Form

Please print all information clearly

MEMBER INFORMATION			
Member Identification Number	Last name	First name	Middle initial
Address – number and street	City	State	Zip code
Gender: ❑ Male ❑ Female	Date of birth: (Month/Day/Year) / /		
Submission instructions:	• Verify if you are eligible for this benefit in your Evidence of Coverage (EOC) document. • You can submit one (1) or multiple requests up to $200 in paid receipts for qualified services. • Submit this form along with an itemized receipt(s) and copy of your health ID card.		

TYPE OF SERVICE	DATE OF SERVICE/PURCHASE	AMOUNT YOU PAID
ACUPUNCTURE		
WEIGHT MANAGEMENT PROGRAM (Weight Watchers)		
NUTRITIONAL /DIETARY BENEFIT		
ACTIVITY TRACKER		
TOTAL AMOUNT SUBMITTED:		

BENEFIT REQUIREMENTS:

Acupuncture: must be provided by a licensed or certified practitioner in the state of New Jersey. A valid receipt must contain practitioner information. **Weight management program:** limited to Weight Watchers (including online). The program may not offer meals as part of the benefit. **Nutritional/dietary benefit:** is a general nutritional education offered to all enrollees through classes and/or individual counseling. It must be provided by a licensed or certified practitioner in the state of New Jersey (i.e., physician, nurse, registered dietician or nutritionist). A valid receipt must contain practitioner information.
An activity tracker: is a wearable device that records a person's physical activity, together with other data relating to their fitness or health, such as the number of calories burned and heart rate. Request for reimbursement can be submitted after purchasing an activity tracker and upon submitting a valid receipt to Horizon BCBSNJ.

CERTIFICATION AND AUTHORIZATION (This form must be signed and dated below)

I authorize the release of any information to Horizon Blue Cross Blue Shield of New Jersey about my services used as part of Flex Benefits. I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services within this calendar year.

Member's Signature: _____ Date: _____

Mail this Flex Benefit form AND attach your original receipt(s) to:

Horizon Managed Care Claims
Horizon Blue Cross Blue Shield of New Jersey
PO Box 820
Newark, New Jersey 07101-0820

Horizon

HorizonBlue.com

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

Spanish (Español): Para ayuda en español, llame al **1-800-365-2223** (TTY **711**).Chinese (中文): 如需中文協助,請致電 **1-800-365-2223** (TTY **711**)。

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