Silver&Fit® Out-of-Network Reimbursement Form

Please complete the reimbursement form, located on the next page, and attach a copy of your completed Fitness Center Member Verification Form and a copy of your proof of payment, showing your name, fitness center, amount paid, and dates covered. Without these forms and proof of payment, we will be unable to consider your reimbursement request.

Please note that reimbursement requests for fitness centers outside of the 50 U.S. states and District of Columbia will not be considered. To be eligible for reimbursement, the fitness center must offer use of cardiovascular exercise equipment (e.g., treadmills, exercise bicycles, stair climbers, etc.), strength or resistance training equipment (e.g., weight/resistance machines, free weights, etc.), and/or instructor-led classes (such as aerobic dance, Pilates, “step” classes, yoga, etc.). Approved fitness centers must have staff oversight, be open to the public, and must offer a membership agreement (or equivalent thereof). Rehabilitation or physical therapy services, personal training sessions, social clubs, sports teams, and leagues are excluded.

It is your responsibility to continuously verify if the out-of-network fitness center you are using joins the Silver&Fit network. You can check status on the Silver&Fit website or directly with the fitness center. You will not be reimbursed for dates in which the fitness center is participating in the Silver&Fit network. Please contact Silver&Fit for more information on what you need to do if your out-of-network fitness center joins the Silver&Fit network.

Please email* or mail your completed forms no later than 90 days after the end of the calendar year. Be sure to include:

- Reimbursement Form
- Fitness Center Member Verification Form
- Proof of Payment

Silver&Fit, P.O. Box 509117, San Diego, CA 92150-9117
Email: fitness@ashn.com

If you have any questions, please call the Silver&Fit program at 1.888.797.7925 (TTY/TDD: 711), Monday through Friday, 8 a.m. to 9 p.m.

*Please do not email photo files (jpeg, png, etc); please email documents in PDF format.
Member Information

Member’s Name (Last, First, MI) _______________________________________________________________
Member’s Date of Birth _____________________________
Member’s Health Plan Name _________________________ Member’s ID Number _____________________
Member’s Address
Street ____________________________ City ________________________ State _______ ZIP ____________
County__________________________________ Phone________________________________

Fitness Center Information

Fitness Center Name _______________________________________________________________________
Fitness Center Address
Street ____________________________ City ________________________ State _______ ZIP ____________
County__________________________________ Phone________________________________

I am requesting reimbursement for the following month(s): (Please note, if you pay your fitness center dues in advance for multiple months, you only have to submit proof of payment once for that period. Automatic payments will be made until your proof of payment expires or benefit maxes.)

☐ January 2020  ☐ February 2020  ☐ March 2020  ☐ April 2020
☐ May 2020  ☐ June 2020  ☐ July 2020  ☐ August 2020
☐ September 2020  ☐ October 2020  ☐ November 2020  ☐ December 2020

NOTICE: This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this reimbursement will be from Federal and State funds, and that any false reimbursements, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal and State laws.

Member’s Signature ___________________________________________ Date ___________________
Excellus BlueCross BlueShield complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.888.797.7925 (TTY/TDD 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.888.797.7925 (TTY/TDD 711).

M950-598G-EXC 07/19 Reimbursement Form © 2019 American Specialty Health Incorporated (ASH). All rights reserved.
Fitness Center Member Verification Form

Fill in your information below, and then have your fitness center complete the rest of the form. Submit this form with your Silver&Fit® Reimbursement Request Form and proof of payment to:

Silver&Fit, P.O. Box 509117, San Diego, CA 92150-9117 or email to fitness@ashn.com

Please be advised that a copy of your fitness center agreement may be requested.

Last Name ____________________________ First Name ____________________________ M.I. __________
Date of Birth ____________________________ Fitness ID ____________________________

Fitness Center Information
Fitness Center Name ____________________________ Fitness Center Phone Number ____________________________
Fitness Center Address ________________________________________________________________________________
City ______________________________________ County _______________________________
State ______________________________________ ZIP+4 __________________ - ___________________

Type of Arrangement
☐ Fitness Center Agreement
☐ Signed Application
☐ Other—Please Explain ________________________________________________________________

Membership
☐ Individual membership ☐ Family membership
Number of family members under this membership: _______

Membership Term
Amount Paid for Membership $ ____________________________
☐ Month-to-Month Start Date ____________ End Date ____________
☐ Annual Membership Start Date ____________ End Date ____________
☐ Other __________________________ Start Date ____________ End Date ____________

Fitness Center Attestation:
I, ________________________________ (fitness center representative name),
confirm that as part of the membership agreement/arrangement with the member listed above, member
has accepted liability and risk for use of the fitness center.

Fitness Center Representative Signature ________________________________
Date ____________________________
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