Blue Cross Blue Shield of TX
Wellness Claim Form

COMPLETE THIS SECTION FOR ALL CLAIMS PLEASE PRINT OR TYPE **Employee ID#**

NAME OF EMPLOYEE	BCBS ID number (found on BCBS ID Card) **ZGP/ZGZ**
Gym Membership ☐ (Only for employees) 10 Visits per month ☐ Receipt/Contract Showing Payment ☐	Weight Watchers or Jenny Craig ☐ (Only for employees) Log showing participation ☐ Receipt Showing Payment ☐
********** Gym Membership Reimbursement OR Weight Watcher/Jenny Craig must be chosen NOT BOTH. **********	
EMPLOYEE'S ADDRESS (NO. STREET, CITY,STATE,ZIP)	
EMPLOYER **LUBBOCK ISD, BlueCross BlueShield of TX, Groups: PPO-Bronze107576/Silver220289, HMO-Bronze251495/Silver251496**	

NAME OF CLAIMANT	DATE OF BIRTH	SEX (M/F)	RELATIONSHIP TO EMPLOYEE
			☐ Employee/Self

**********You have 30 days to submit a claim, example: Submit January in February, etc.**********

AUTHORIZATION: THE ABOVE ANSWERS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE ANY PHYSICIAN, SURGEON, PRACTITIONER OR OTHER PERSON, AND HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITALS, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION, OR ORGANIZATION, TO RELEASE TO EACH OTHER ANY MEDICAL OR OTHER INFORMATION ACQUIRED, INCLUDING BENEFITS PAID OR PAYABLE, CONCERNING THIS OR OTHER DISABILITIES. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL, AND DELIBERATE MISREPRESENTATION OR FRAUD BY THE INSURED OR ON BEHALF OF THE INSURED SHALL RENDER VOID ANY AND ALL POLICIES AND/OR CERTIFICATES ISSUED BY THE LUBBOCK I.S.D. HEALTH BENEFIT PLAN.

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Employee Signature Date

This form may be photocopied or you may call the Risk Management Office at 219-0282.