



# HIP Health Plan of New York Health Club Reimbursement Form

Please complete all of the information requested below. Remember to attach a copy of your current health club facility bill showing the cost of your membership\* and proof of payment (receipts, cancelled checks). Submit this form and other material to the address below:

HIP Health Plan of New York  
JAF Station  
PO Box 2884  
New York, NY 10116

Available only to members enrolled in the following small group plans:

- HIP Select EPO
- HIP Select PPO
- HIP Classic HMO

### MEMBER INFORMATION:

|  |  |  |                                       |  |  |                      |  |  |
|--|--|--|---------------------------------------|--|--|----------------------|--|--|
| Last name _____  |  |  | First name _____                      |  |  | Middle initial _____ |  |  |
| HIP ID # _____   |  |  | Member date of birth (mm/dd/yy) _____ |  |  |                      |  |  |
| Name and address of health club facility where you are an active member: |  |  |                                       |  |  |                      |  |  |
| Name of health club _____  |  |  |                                       |  |  |                      |  |  |
| Street address _____   |  |  |                                       |  |  |                      |  |  |
| City _____   |  |  | State _____                           |  |  | ZIP _____            |  |  |
| Date of membership: From (mm/dd/yy) _____ To (mm/dd/yy) _____            |  |  |                                       |  |  |                      |  |  |
| Total annual membership fee: _____                                       |  |  |                                       |  |  |                      |  |  |
| Total amount paid by member: _____ Date of final payment: _____          |  |  |                                       |  |  |                      |  |  |

\*Annual membership fees exclude initiation fees paid to facility. Reimbursement by HIP Health Plan of New York will be made once the entire annual membership is paid in full. No proof of installment payments should be submitted to HIP Health Plan of New York unless the total amount of all installments paid is equal to the annual membership cost. HIP Health Plan of New York will not reimburse members on an installment basis. Annual membership is defined as a 12 consecutive month period with no interruptions. Reimbursement may need to be prorated based on the portion of the year members are enrolled in a health benefits plan with this covered benefit. If you have any questions regarding your eligibility to receive the health club reimbursement benefit, please check your Certificate of Coverage or call **1-800-HIP-TALK (1-800-447-8255)**.

### FOR INTERNAL USE ONLY:

Cpt code: GYM12    POS: 99    Provider Lic: MEMREIMNY 001    Prov TIN: MEMREIMNY 000    ICD9: V690