Geisinger
Health Plan

Healthy Rewards Reimbursement Request Form

Please submit one reimbursement request form per member.
Complete this form to request your reimbursement of up to $100/single or $200/family per benefit period for completing a health risk assessment (HRA) and for participating in qualified activities (if you are requesting reimbursement for activities completed by family members, you must submit a separate reimbursement form for each member). Please complete the information requested below and return this form(s), along with a valid receipt to the address listed at the bottom of this form.

Subscriber last name First name Date of birth Phone number

Street address City State Zip

Step 1- Complete activity for reimbursement information and include a receipt.

Reminder, a separate form must be completed for each family member. Please check one or more qualified activities and include the name and ID number of the member for whom reimbursement is being requested. You must include a **valid receipt showing the amounts paid** for the activity(ies) indicated. The receipt must be for activities occurring within the current benefit period. The receipt should include the name and address of the business or organization along with the amount paid and the date of the activity. Canceled checks with the activity listed in the memo line including the date of the activity are also considered to be valid receipts. Reimbursement is issued for amounts paid only. Contracts for services and rate sheets are not considered valid receipts.

Member name:_____ Member ID:_____ Date of birth:_____

Fitness center membership

☐ Individual membership ☐ Family membership **Membership period:** From ___/___/___ to ___/___/___

Membership type: ☐ Annual ☐ Monthly ☐ Other (please specify):_____

Other activities

Activity for reimbursement	Date paid	Amount paid	Activity for reimbursement	Date paid	Amount paid	Activity for reimbursement	Date paid	Amount paid
Soccer			Lessons (golf, dance, etc.)			Karate, Tae Kwon Do, etc.		
Hockey			Basketball			Cycling		
School athletic activity fees (registration related)			Baseball/softball (including Little League)			Weight Management Program (registration/ member fees)		
Lacrosse			Volleyball			Tennis		
Gymnastics			Cheerleading			Football		
Swimming lessons /team fees			Exercise classes (aerobics, yoga, etc)			Sports camps/leagues/ clubs		
Registration/race/ tournament fees			Personal training at a fitness center			**Total reimbursement requested $_____**		

Please see page 2 for a list of activities that are not eligible for reimbursement and to certify your activity.

Ineligible activities

Examples of activities that do not qualify for reimbursement are: uniforms, athletic clothes, shoes and equipment, exercise and sporting equipment, fitness DVDs, hunting and fishing equipment or fees, miniature golf, amusement parks, food and supplements in general and associated with weight management programs, admission to sporting events, bowling, recreational activities to include greens fees, driving range fees, ski lift tickets, ice skating, roller skating, rock climbing, skate/bike parks, community and private pools, indoor trampoline facilities.

Activity certification: I certify that the activity information on page 1 is correct to the best of my knowledge. I am claiming reimbursement for eligible activities incurred during the applicable benefit period for eligible members.

Subscriber's signature: _____ Date: _____

Step 2-Verify completion of your health risk assessment

Completion of an HRA is required by the **subscriber** prior to reimbursement being issued. Log on to the secure member section of TheHealthPlan.com, select the "Health and Wellness" link from the options on the left. Next select "Health Risk Assessment" from the options on the left. Then follow the instructions provided for completing your HRA. Please be sure to sign the statement below verifying that your HRA has been completed.

HRA certification

I certify that I have completed the HRA available via thehealthplan.com on the date indicated below during my current benefit period or during my prior benefit period in conjunction with an organized wellness program. Note: The subscriber only needs to complete one HRA per benefit period. If you have already completed an HRA during this benefit period, please re-sign on the line below and include the original date that you completed your HRA.

Subscriber's signature: _____ Date of HRA: _____

Reimbursement is subject to approval by Geisinger Health Plan.

**Your receipts may be reviewed retroactively for validation purposes. If, upon review, your receipt is determined to be invalid, or we have no record of your HRA completion, we reserve the right to reconsider prior reimbursement payments. Please allow 4-6 weeks from receipt for reimbursements. If you have any questions regarding your reimbursement, please contact us at the telephone number on the back of your member identification card.*

Mail completed form with receipts to:

Geisinger Health Plan
Attn: Healthy Rewards Reimbursement
PO Box 8200
Danville, PA 17821-8200