THE OHIO STATE UNIVERSITY
HEALTH PLAN

Return Form To:
Trustmark Health Benefits
ATTN: OSU Health Plan Member Claims
PO Box 2310
Mt. Clemens, MI 48046
OSUMemberSubmissions@trustmarkbenefits.com

HOSPITAL BASED/PHYSICIAN DIRECTED WEIGHT LOSS PROGRAM REIMBURSEMENT FORM

1. Participant's first name: _____ Participant's last name: _____	2. Participant Date of Birth: Month Day Year _____ / _____ / _____ 3. Relation to member: Self ☐ Spouse ☐ Child ☐ Other ☐	4. Member ID #: _____
5. Member first name: _____ Member last name: _____	6. Member address: _____ _____	

NOTE: Reimbursement is based on attendance and payment of program costs. Reimbursement will not be greater than 50% of amount paid-to-date by member.

Requirements for reimbursement:

- ✓ Copy of Itemized Payment Receipt (only program costs are eligible for reimbursement, not supplements, gym memberships, etc.)
- ✓ Attendance Record (Page 2) which is to be completed at the class by a PROGRAM facilitator. If more spaces are needed, please use additional copies of page 2.

Reimbursement is based on a minimum of 6 sessions attended or at program end if less than 6 remaining.
Reimbursement checks will be made out to the member and mailed to his/her home address.

Program Name: _____

Program Location: _____

Program Facilitator (Name): _____

Program Facilitator (Phone): _____

Duration of Program (weeks): _____ Program Start Date: _____ / _____ / _____

Cost of Program per week: _____

OSU Health Plan reserves the right to verify attendance and payment of services in the program before reimbursement of benefit.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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7. Participant's first name: _____ Participant's last name: _____	8. Participant Date of Birth: Month Day Year _____ / _____ / _____ 9. Relation to member: Self ☐ Spouse ☐ Child ☐ Other ☐	10. Member ID #: _____
11. Member first name: _____ Member last name: _____	12. Member address: _____ _____	

Date **Program facilitator verifying attendance (please print and sign name)**

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