



**Return Form To:**  
**CoreSource**  
**ATTN: OSU Health Plan Member Claims**  
**PO Box 2310**  
**Mt. Clemens, MI 48046**  
[OSUMemberSubmissions@coresource.com](mailto:OSUMemberSubmissions@coresource.com)

**HOSPITAL BASED/PHYSICIAN DIRECTED WEIGHT LOSS PROGRAM REIMBURSEMENT FORM**

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

**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.**



**THE OHIO STATE UNIVERSITY**

HEALTH PLAN

**HOSPITAL BASED/PHYSICIAN DIRECTED WEIGHT LOSS PROGRAM REIMBURSEMENT FORM**

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: _____ _____	

<u>Date</u>	<u>Program facilitator verifying attendance (please print and sign name)</u>
_____	_____
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