



I am requesting reimbursement up to \$20 per month toward dues at a participating sports fitness facility.

Fitness Benefit Reimbursement Form

VIVA MEDICARE reimburses you up to \$20 per month toward membership dues at a participating sports fitness facility. You are responsible for any amount over \$20 per month.

- 1) Fully complete Sections 1-3 of this form. Please use dark ink and print clearly.
- 2) Enclose your original receipts. Please do not attach receipts to this form.
- 3) Keep copies of receipts for your records. Receipts will not be returned.
- 4) Mail the completed form with receipts to VIVA MEDICARE no later than one (1) year after the month for which you are requesting reimbursement. See Section 4 for mailing instructions.
- 5) Reimbursement cannot be made for future months.

Section 1 – Member Information		
Member Number (on your member ID card)	Member Name	
Address Line 1	Date of Birth	Phone Number
Address Line 2	City	State/ZIP code
Section 2 – Enclosed Receipts		
<p>Fitness receipts must contain:</p> <ul style="list-style-type: none"> ▪ Your name ▪ Name of fitness facility ▪ Month/year reimbursement is for ▪ Proof of payment 		
<ul style="list-style-type: none"> ▪ Contact the fitness facility if you need additional information. 		
Section 3 – Signature		
The above statements and enclosed receipts are true and complete to the best of my knowledge.		
X _____ <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 0;"> Signature Date </div>		
Section 4 – Mailing Instructions		
Mail to: VIVA MEDICARE Claims Department 417 20 th St. No., Suite 1100 Birmingham, AL 35203		Questions? Call Member Services: 1-800-633-1542 toll free TTY users: Alabama Relay Service at 711 Monday - Friday, 8 a.m. - 8 p.m. From October 1 to February 14, 7 days a week, 8 a.m. - 8 p.m.