

STATE OF IDAHO WEIGHT LOSS PROGRAM REIMBURSEMENT FORM

I _____, give permission to _____
(weight loss program) to send my information to Blue Cross of Idaho in order to receive reimbursement for the weight loss program. I understand that all information will be regarded as confidential and will only be used for reimbursement and tracking purposes.

Name: _____ BCI ID#: _____

Signature: _____ Date: _____

Address: _____

To be filled out by weight loss program director or instructor

Date of initial assessment: _____

Client's Name: _____ Client's Age: _____

Department: _____ County: _____

Starting Weight: _____

Weight at 6 months _____ Percent loss _____

Weight at 12 months _____ Percent loss _____

Program director or instructor's signature: _____

Please send to:

Blue Cross of Idaho
Attn: Heather Myklegard
P.O. Box 7408
Boise, ID 83707