



Childbirth Class Reimbursement Form

For Massachusetts members with: 1) individual coverage, or 2) coverage through an employer group with 50 or fewer employees. (If you're not sure if you qualify, please check with your employer.) Please read the instructions below, then fill out the form on page 2.

Keep copies of all documentation before sending in your Childbirth Class Reimbursement Form.

Mailing Instructions

Please enclose copies of the following:

1. Completed and signed Childbirth Class Reimbursement Form
2. Paid receipts verifying enrollment in a qualifying childbirth education class (Receipts from the program must show name of the member, name/location of the class, amount paid and date paid.)
3. Mail the Childbirth Class Reimbursement Form and all documentation to:
Harvard Pilgrim Health Care
P. O. Box 9185
Quincy, MA 02269

Commonly Asked Questions and Answers

How do I qualify for a reimbursement?

- Your plan must include Harvard Pilgrim's Childbirth Class Reimbursement benefit. Check with your employer or see your *Schedule of Benefits* for details.
- You may only submit for reimbursement once per pregnancy.

When can I submit my Childbirth Class Reimbursement Form?

You must submit the form before the end of the calendar year following the year for which you are requesting reimbursement.

How much can I claim for reimbursement?

- Subscribers may claim up to the full cost of a childbirth education class for themselves and/or their dependents.
- Reimbursement will not exceed the cost of the childbirth class.
- Subscribers may receive reimbursement for a childbirth class only once per pregnancy.

What happens once I submit the Childbirth Class Reimbursement Form?

- Reimbursement checks will be made payable to the Subscriber and mailed only to the Subscriber's address of record. No alternative address will be accepted.
- If you believe your current address is different than the address of record in Harvard Pilgrim's systems, please contact us before submitting your Childbirth Class Reimbursement Form.
- Please allow up to 8 weeks for processing.

This information refers to plans offered by Harvard Pilgrim Health Care and its affiliates, including Harvard Pilgrim Health Care of New England and HPHC Insurance Company.



Childbirth Class Reimbursement Form

To be filled out by Harvard Pilgrim Health Care **SUBSCRIBER** only. Please use blue or black ink and print all information clearly.

When to submit this form

- After you enroll in a Harvard Pilgrim plan that includes the Childbirth Class Reimbursement benefit.
- After you have enrolled in and paid for a childbirth education class.
- Once per pregnancy with all necessary receipts and documentation.
- Once all sections on the form have been completed and signed by the subscriber.

Section A – Subscriber Information (person who holds coverage)

Harvard Pilgrim ID Number	Subscriber’s Last Name	First Name	Middle Initial
Date of Birth (mm/dd/yyyy)			
Address	City	State	ZIP Code
Daytime Phone (area code) xxx-xxxx	Company Name (Employer)	Subscriber’s Email	

Section B – Subscriber and/or Member Information for Reimbursement

Harvard Pilgrim ID Number	Last Name	First Name	Date of Birth (mm/dd/yyyy)
Harvard Pilgrim ID Number	Last Name	First Name	Date of Birth (mm/dd/yyyy)
Harvard Pilgrim ID Number	Last Name	First Name	Date of Birth (mm/dd/yyyy)

Section C – Childbirth Class Information *(List all programs that you are submitting for on behalf of you and/or your dependents, including dates.)*

ATTACH DOCUMENTATION	Calendar Year from: mm/dd/yyyy to: mm/dd/yyyy	Name of Program	City, State	Phone Number (Area Code) xxx-xxxx	\$ Amount being claimed
	from: ___/___/___ to: ___/___/___				
	from: ___/___/___ to: ___/___/___				
	from: ___/___/___ to: ___/___/___				

Total number of documents _____ Total dollar amount being claimed \$ _____

Section D – Subscriber Certification

I certify that the information on the form and all supporting documents are complete, accurate and unaltered. I affirm that I and/or my covered dependent(s) attended the childbirth class for which I am being reimbursed.

Subscriber’s Signature _____	Date _____
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Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-333-4742 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-888-333-4742 (TTY: 711).

繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-333-4742 (TTY: 711)。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quý vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quý vị miễn phí. Gọi số 1-888-333-4742 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-333-4742 (телетайп: 711).

العربية (Arabic)

إنتباه: إذا أنت تتكلم اللغة العربية، خدمات المساعدة اللغوية متوفرة لك مجاناً. إتصل على 1 888-333-4742 (TTY: 711)

ខ្មែរ (Cambodian) ប្រសូជនដំណឹង: បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).


Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-333-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-333-4742 (TTY: 711).

 Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below (“HPHC”) comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

