Transplant RECIPIENT Travel Reimbursement Form

We understand that this is a difficult time for you and your family. Our team stands ready to help so you receive the appropriate benefits for your transplant-related expenses.

In order to receive reimbursement according to your benefits, please submit the following documentation:

- This **Transplant RECIPIENT Travel Reimbursement Form**, completed legibly and in its entirety.
- All receipts. These must be legible and match the information provided on this form.
- A log of miles traveled. Eligible travel reimbursement is provided only for travel of more than 100 miles.

See page 2 of this form for excluded expenses.

Donor expenses must be submitted separately using the Transplant DONOR Travel Reimbursement Form.

Transplant Center (Facility Name/City/State): _____

Name of subscriber:	**Member ID # :**	**Member date of birth:**
Transplant recipient name:	**Recipient's relationship to subscriber:** ☐ **Self** ☐ **Other**	**Transplant recipient email address:**
Traveling companion/caregiver* name:	**Relationship of companion/caregiver* to recipient:** ☐ **Spouse** ☐ **Other**	**Total number of receipts included:**
Member address:	**City, State, Zip:**	
Donor name (if known):	***Traveling companion/caregiver is limited to a parent, spouse, child, sibling, or any person residing with the transplant recipient.	

Travel date(s) *travel date(s) **TO** the hospital facility*	**Travel date(s)** *travel date(s) **FROM** the hospital facility*	**Transportation** *air, bus, pre-approved rental car*	**Lodging** *up to $200.00 per person per night, not to exceed 2 persons*	**Personal Car Mileage** †*based on IRS rate for medical travel*	**Meals** *up to $75 per person per day, not to exceed 2 persons*	**Total**
Ex: 8/24/2019		*$0*	*$210.55*	*$22.00*	*$82.25*	*$314.80*
Totals:						

†IRS mileage reimbursement rate for medical travel is published on the IRS website at www.irs.gov.

I agree that each trip shown above was for travel and mileage that is allowed. I also agree that no other agency can pay me back for the trip and mileage. I understand that if I hold back any facts or document things that are not true, I may be doing something that is against the law. In that case, I could lose my benefits, have to pay money back, or face legal actions.

Signature:_____ **Date:** _____

Please Note: *A signature is required by the member or companion; or if you are filing the claim on behalf of a member who is over the age of 18, you must provide a Power of Attorney or Appointment of Representative. Signature must be legible to determine payment eligibility.*

For internal use only: Diagnosis Number: _____ Provider ID: _____

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Form Instructions

You must submit these documents within 6 months from the date the services were received, unless timely filing was prevented. Please be advised that it may take up to 60 days to receive a determination of your request.

Complete all applicable sections on the form.

- The full name of the transplant recipient
- The Member ID and home address
- The full name of the member traveling companion
- The place of service where the transplant occurred
- The date of each travel expense
- The description and/or charge for each daily travel expense incurred

Transplant services must be pre-authorized to receive travel reimbursement.

Exclusions and Specifications

The following are specifically excluded from reimbursement under any circumstances. Other expenses not listed below also may be denied if they are not preapproved.

- Alcoholic beverages
- Vehicle maintenance
- Vehicle insurance
- Flight insurance
- Child care services/Daycare
- Cards, stationery, stamps, etc.
- Clothing
- Dry cleaning
- Entertainment
- Flowers
- Household products
- Household utilities
- Kennel services
- Laundry services
- Non-hospital parking
- Security deposits
- Telephone calls
- Tobacco products
- Toiletries
- Any services/products purchased outside of the United States of America

If you have questions regarding your benefits, please call the customer service telephone number listed on your Ambetter Health ID card.

Send completed form to Ambetter Health Plan by mail **WITH RECEIPTS** and **MILEAGE LOG** attached. Please keep photocopies of your bills, receipts, and supporting documentation for your personal records.

AMBETTER HEALTH PLAN
Attn: Claims Department - Member Reimbursement
P.O. Box 9040
Farmington, MO 63640-9040

AMB19-AZ-C-00354