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 within one year from date of travel*:

- 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 60* miles.

* One year requirement will be waived if you or your covered dependent member had no legal capacity to submit such proof during that year.

** This minimum mileage requirement varies by state. Check with your Care Coordinator to confirm the requirement for your plan.

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:**	
†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 per day for Recipient and for one traveling Companion/ Immediate Family member*	**Personal Car Mileage** *††based on IRS rate for medical travel*	**Meals** *up to $75 per day for Recipient and for one traveling Companion /Immediate Family member*	**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.*

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

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.

a. Alcohol/tobacco
b. Car Rental (unless pre-approved by the Center of Excellence)
c. Vehicle maintenance for motorized and hybrid, and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.)
d. Parking, such as but not limited to hotel, valet or any offsite parking other than hospital
e. Storage rental units, temporary housing incurring rent/mortgage payments
f. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.
g. Speeding tickets
h. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
i. For any services related to pet care, boarding, lodging, food, and/or travel expenses; other than those related to certified/registered service animal(s)
j. Expenses for persons other than the patient and his/her covered companion
k. Expenses for lodging when member is staying with a relative
l. Any expense not supported by a receipt
m. Upgrades to first class travel (air, bus, and train)
n. Personal care items (e.g., shampoo, deodorant, clothes)
o. Luggage or travel-related items including passport/passport card, REAL ID travel ids, travel insurance, travel agency fees, TSA precheck, and early check-in boarding fees, extra baggage fees
p. Souvenirs (e.g., t-shirts, sweatshirts, toys)
q. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type
r. All other items not described in the policy as eligible expenses
s. Any fuel costs/charging station fees for any vehicle
t. Any tips, concierge, club level floors, and gratuities
u. Salon, barber, and spa services

If you have questions regarding your benefits, please call the customer service telephone number listed on your Ambetter from NH Healthy Families ID card or your transplant coordinator through the Center of Excellence.

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

Ambetter from NH Healthy Families, Attn: Claims Department - Member Reimbursement
P.O. Box 5010

Farmington, MO 63640-5010