# Transplant Travel Reimbursement Form

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

In order to receive reimbursement according to your benefit, we need you to complete this form which documents travel expense for transplant related services. For this, all travel related expenses must include legible receipts. Recipient/Companion and Donor expenses must be submitted separately.

Please check one: ☐ Transplant Recipient/Companion ☐ Transplant Donor

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

| Name of Subscriber: | Member ID # : | Member DOB: / / | Transplant Recipient Name: | Relationship to Subscriber: ☐ Self ☐ Other |
|---|---|---|---|---|
| Recipient Email Address: | Companion/Caregiver Name: | Relationship to Recipient: ☐ Spouse ☐ Other | Donor Name: | Relationship to Recipient: ☐ Spouse ☐ Other |
| Total Number of Receipts Included: | | Subscriber/Donor Address: City, State, Zip: | | |

| Travel date(s): Note: travel dates to the hospital facility | Travel date(s): Note: travel dates from hospital facility | Transportation (S9975): air, bus, rental car, parking | Lodging (S9975): | Personal Car Mileage (S9975): .235 per mile 2014/.23 per mile 2015 | Total |
|---|---|---|---|---|---|
| Ex: 8/24/2014 | 8/25/2014 | $0 | $69.55 | $23.50 | $93.05 |
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| Totals: | | | | | |

**Notes:** ______________________________

*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 put down 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, legal appointed representative, if filing claim on behalf of a member over the age of 18. Signature must legible to determine payment eligibility.*

**SEND COMPLETED FORM TO AMBETTER BY MAIL WITH RECEIPTS and MILEAGE LOG ATTACHED.**

Ambetter
Attn: Claims Department - Member Reimbursement
P.O. Box 5010
Farmington, MO 63640-5010

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

***For internal use only:***

Diagnosis Number________ ______________ Provider ID:____________________

# Transplant Travel Reimbursement Form

**Form Instructions:**

Please use this form to file your Travel Reimbursement Request. You must submit these documents within 180 days from the date the services were received, unless timely filing was prevented. Please be advised that this process 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 patient receiving the service
- The patient's member ID and home address
- The full name of the subscriber companion
- The place of service the transplant occurs
- The date of each travel expense
- The description and/or charge for each daily travel expense incurred

Form must be completed and legibly in its entirety. In addition to this completed form, Ambetter requires you to attach a copy of your approved Travel Pre-Authorization Form and all legible receipts. The receipts must match the information you provide in this form. A log of miles traveled must also be included.

Please keep photocopies of your bills and supporting documentation for your personal records.

*In order to file a claim on behalf of a member, you must provide a power of Attorney or an Appointment of Representative

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

**Exclusions and Specifications**
The following are specifically excluded from reimbursement under any circumstances (other expenses not included below may be denied if they are not preapproved.)

- Meals
- Alcoholic Beverages
- Car 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
- Security Deposits
- Toiletries

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