BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

MILEAGE REIMBURSEMENT REQUEST

Use this form only when requesting reimbursement for qualified mileage expenses from your Health FSA/HRA. Mileage to obtain qualified medical services and prescriptions for yourself and a qualified depependent are eligible for reimbursement. Mileage allowance is to and from your home adresss to the provider of service.
* Be sure to complete, sign and date this form before mailing or faxing to the contacts listed below.

SECTION 1: EMPLOYEE INFORMATION

FIRST NAME | **MI** | **LAST NAME**

DATE OF BIRTH (MONTH DAY YEAR)

PREFERRED BLUE ACCOUNT NUMBER (PREFIX)

Your Preferred Blue Account number is your Blue Cross and Blue Shield of Alabama contract number. If you do not have your account number, please contact Customer Service at 1-800-213-7930.

COMPANY NAME

WORK PHONE (Please include area code)

HOME PHONE (Please include area code)

SECTION 2: MEDICAL MILEAGE REIMBURSEMENT REQUEST - TRIP LOG

TRIP	PATIENT NAME	DATE OF SERVICE	DESTINATION/PROVIDER NAME	TOTAL MILEAGE (Round Trip)*
1		/ /		
2		/ /		
3		/ /		
4		/ /		
5		/ /		
6		/ /		
7		/ /		
8		/ /		
9		/ /		
10		/ /		
11		/ /		
12		/ /		
13		/ /		
14		/ /		
15		/ /		
16		/ /		
			TOTAL MILES	

***Mileage Rate: The mileage rate is set by the IRS and reimbursement is based on the rate in effect on the date of service. Blue Cross Blue Shield of Alabama will calculate the reimbursement based on the IRS allowed amount per mile. To find the mileage rates please refer to the IRS website at http://www.irs.gov/pub/irs-pdf/p502.pdf. It will indicate the amount of $0.xx per mile traveled.**

I certify that the attached expenses are eligible for reimbursement from my designated Health FSA/HRA and that they qualify as deductions as outlined by the U. S. Internal Revenue Code. I request reimbursement up to the limit allowed in my account. I further certify that these expenses have not been reimbursed and are not reimbursable under any other benefit plan. A dependent must be considered an eligible dependent under the applicable provisions of section 105 and 106 of the U.S. Internal Revenue Code.

Signature of Employee | Month | Day | Year

Important: This form is not used to reimburse you for your Blue Cross and Blue Shield of Alabama health benefits. It may only be used to request a payment from a tax-deferred, employee-funded spending account established by your employer under Section 125 of the U.S. Internal Revenue Code or from your HRA established by your employer. Payments from such an account may only be made for qualified expenses on behalf of qualified dependents when such expenses have not been reimbursed and are not reimbursable by any other benefit plan.

Blue Cross and Blue Shield of Alabama
Preferred Blue Accounts
P.O. Box 11586
Birmingham, Alabama 35202-1586
1-800-213-7930
Toll Free Fax 1-877-889-3610

Visit our web site **www.bcbsal.com** for detailed account information

HELPFUL TIPS FOR SUCCESSFULLY COMPLETING AND FILING YOUR MEDICAL MILEAGE REIMBURSEMENT REQUEST

1. Complete your Medical Mileage Reimbursement form legibly. If your form cannot be read, it cannot be processed.

2. Use one row for each round trip. Each trip listed should match with a medical service provided for yourself or eligible dependent.

3. Submitting the Medical Mileage form does not require that you submit supporting documentation, however, IRS regulations state that you should retain appropriate documentation to support corresponding medical trip you list on your mileage log.

Documentation for the medical mileage claim should include:
- The date of service (the date you incurred the expenses)
- Name of the service provider/or destination
- To whom the service was provided (patient's name)
- The total miles you traveled (round trip)

Retain the documentation in your files.

4. What is acceptable medical or perscription documentation to support your mileage log?
   Examples of good documentation are:
   - An Explanation of Benefits (EOB) from your insurance carrier showing the above information.
     If the EOB indicates the procedure is not covered by your health insurance plan, you may be required to submit an itemized statement from the provider.

   - For prescription drugs, a pharmacy statement including the name of the pharmacy, patient's name, date the RX was filled, patient's cost, RX number and name of the drug.

   - For over- the-counter (OTC) medications, as of January 1, 2011, a doctor's prescription is required.

5. Sign your form: An unsigned form will stop your reimbursement.

6. Fax or Mail your form to the contacts listed on the front of this form.