

Transplant Travel Reimbursement Form



Please fill in the form below, attach appropriate receipts, and mail to:

Providence Health Plans, Transplant Claims, Suite T, PO Box 4327, Portland, OR 97208-4327

Please keep a copy of all forms and other items submitted and check your member contract for exact benefits.

- The transplant travel benefit is limited to services provided to the member:
(1) The evaluation; (2) the trip to the transplant center for the transplant procedure (if this requires a separate trip from the evaluation); and (3) the initial post-transplant period after discharge, during which the transplant recipient is required to remain in the local area of the transplant facility. Once the transplant provider releases you to return home, the benefit ends. It does not apply to subsequent trips to the transplant facility for post subsequent care.
- Benefits are not available during the time the recipient is an inpatient in the hospital.
- Receipts are required for all reimbursement, with the exception of mileage reimbursement if you are traveling by automobile.
- **There is a \$300 limit per day for food & lodging for recipient.** Toiletries, personal items, alcoholic beverages, and magazines are not covered.
- **Food receipts must be itemized by circling the transplant recipient's items. Lodging receipts must be itemized and on hotel/property management letterhead.** Transportation reimbursement is limited to one roundtrip for the evaluation, and one roundtrip for the transplant. Parking fees not covered unless part of hotel charges.
- Automobile-related reimbursement is based on the roundtrip mileage from your home to the transplant center and reimbursed per the federal mileage reimbursement for personal cars being driven for medical purposes.
- Receipts must be submitted within 12 months of incurred expense to be eligible for reimbursement.
- Medical deductible applies to the maximum transplant travel reimbursement travel limit. **There is a \$5,000 per transplant maximum benefit for transplant travel.**

Transplant Recipient Information:

TRANSPLANT RECIPIENT NAME

TRANSPLANT RECIPIENT MEMBER ID

Date Range(s) for Reimbursement:

FROM ____/____/____ TO ____/____/____

- Initial / Pre-surgical evaluation(s)
- Trip to transplant center for transplant procedure
- Follow-up visit

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Total reimbursement requested for lodging:**\$**

NAME OF HOUSING FACILITY/HOTEL

ADDRESS

ROOM OR APT #

CITY

STATE

ZIP

() -
PHONE NUMBER**Total reimbursement requested for food:****\$**

(Attach itemized receipts)

Please submit verifiable contract or receipt. Some items are not eligible for reimbursement including refundable deposits, furnishing rental/purchases, and phone charges.

Reimbursement check to be sent to:

ADDRESS

CITY

STATE ZIP

SIGNATURE

DATE / /

DISCLAIMER: This benefit is subject to the coverage described in your medical benefit plan and is reimbursable up to any identified limits, after deductible. However, certain portions of this travel benefit may not fall within the IRS definition of "medical care," for tax purposes. Please consult with your employer benefits team to determine if using portions of these benefits could have tax-related impacts for you. If you have a high deductible health plan, you should contact your HSA vendor for any questions regarding what specific costs can be paid for using your HSA account. Providence Health Plan is not responsible for any employer and/or employee tax considerations, obligations, and/or impacts as may relate to specific plan benefits offered within your plan.