

TRANSPORTATION AND LODGING BENEFIT (NOT RELATED TO TRANSPLANT OR GENE THERAPY)



An Independent Licensee of the Blue Cross Blue Shield Association

THIS FORM ONLY APPLIES IF YOUR HEALTH PLAN INCLUDES A TRAVEL BENEFIT FOR ONE OF THE SERVICES NOTED BELOW. REVIEW YOUR SUMMARY OF BENEFITS COVERAGE TO SEE IF YOU ARE ELIGIBLE.

Our team stands ready to help guide you so that you may receive appropriate benefit for your expenses. In order to receive reimbursement according to your benefit, we need you to complete this form which documents travel expenses for one of the below services. For this, all travel related expenses must include legible copies of your receipts. Please make copies of your documentation in case they are lost in the mail.

As a reminder, your plan may not cover the services listed below. Please check your Summary of Benefits and Coverage to see what's a covered benefit.

Please check one:

- | | | |
|--|---|---|
| <input type="checkbox"/> Behavioral health treatment | <input type="checkbox"/> Maternity/reproductive health services | <input type="checkbox"/> Transgender services, including gender affirmation treatment |
| <input type="checkbox"/> Cancer treatment | <input type="checkbox"/> Musculoskeletal procedures | <input type="checkbox"/> Weight reduction/bariatric procedures |
| <input type="checkbox"/> Cardiac services | <input type="checkbox"/> Pregnancy termination services | |

Treatment center name, address, and phone number: _____

Mail your completed form and documentation to BCBSAZ, P.O. Box 2924, Phoenix, AZ 85062-2924.

You will be reimbursed via check, mailed to the address we have on file within 30 days of Blue Cross® Blue Shield® of Arizona (BCBSAZ) receiving your reimbursement information.

SECTION 1 – CARDHOLDER INFORMATION			
Cardholder's ID Number	Group/Employer or Plan Name		Group No. Required if on ID Card
Cardholder's Name (Last, First, Middle Initial)	Date of Birth (mm/dd/yyyy) / /	Cardholder's Phone Number	
Cardholder's Address (Street, City, State, ZIP)			

SECTION 2 – PATIENT INFORMATION	
Relationship to Subscriber	
<input type="checkbox"/> Self <input type="checkbox"/> Other	
Patient's Name (Last, First, Middle Initial)	Date of Birth (mm/dd/yyyy) / /

SECTION 3 – TRAVEL INFORMATION					
Travel Date(s) Note: Travel dates TO the hospital facility	Travel Date(s) Note: Travel dates FROM the hospital facility	Transportation (S9975) Air, bus, rental car, parking	Lodging (S9975)	Personal Car Mileage (S9975) 2014 – \$0.235 per mile 2015 – \$0.23 per mile	Total
Ex: 8/24/2014	8/25/2014	\$0	\$69.55	\$23.50	\$93.05
Totals:					

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. 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.

SECTION 4 – ATTESTATION CERTIFIES THAT THE INFORMATION PROVIDED ABOVE IS TRUE, ACCURATE, AND COMPLETE.	
Member's Signature	Today's Date (mm/dd/yyyy) / /

Questions? Call the number on the back of your insurance card.

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, BCBSAZ 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 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 | • Clothing | • Laundry Services |
| • Alcoholic Beverages | • Dry cleaning | • Security Deposits |
| • Car Maintenance | • Entertainment | • Toiletries |
| • Vehicle Insurance | • Flowers | |
| • Flight Insurance | • Household products | |
| • Child Care Services/Daycare | • Household utilities | |
| • Cards, stationery, stamps, etc. | • Kennel Services | |



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