



## **Travel and Lodging Reimbursement Form for Expenses Relating to Eligible Out-Of-Area Organ and Tissue Transplant(s)**

We understand that this is a difficult time for you and your family. We are ready to help guide you, so you receive appropriate reimbursement for your out-of-area transplant-related services. To receive reimbursement according to your benefits, please complete this form and include receipts where noted.

If you have any questions regarding this benefit, please call the number on the back of your member ID Card.

### **Eligibility**

To be eligible for this benefit, the transplant service must be performed at a Centers for Medicare and Medicaid Service (CMS) approved facility located greater than 75 miles from the member's legal permanent residence. The following types of transplants are covered for this benefit: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivesicular. This benefit applies to the Medicare Advantage member and one companion to accompany the patient. A companion may be a spouse, family member, legal guardian, or any person not related to the member but actively involved in the member's care. Patients who are minors are allowed travel benefits for themselves, one or both parents, or a parent and designated companion.

### **Reimbursement**

Automobile expenses (mileage and gas) will be reimbursed at the IRS medical mile-approved rate in effect on the date of travel, which can be found at [www.irs.gov](http://www.irs.gov) and based on an objective source such as Google Maps/MapQuest. Tolls and parking are reimbursable while traveling to the transplant center with a receipt.

- Airfare reimbursement is limited to coach or economy fares. This includes the cost for one bag per covered person. Additional baggage fees are excluded.
- When rental vehicles are used, rental fees are covered, but mileage will not be reimbursed separately.
- Reimbursement of lodging will be based up to the per diem rate for lodging specified by the U.S. General Services Administration, which is available at [www.gsa.gov](http://www.gsa.gov) or the actual cost of the lodging based on submitted receipts, whichever is less.
- The maximum amount payable for travel and lodging related to the initial transplant is limited to \$10,000.00 per transplant.
- Travel receipts must be submitted within 365 days (1 year) from the date of discharge.
- Limited to the Transplant Period which is defined as 5 days prior to the transplant and ends when the member returns home after discharge from inpatient (Skilled Nursing or Rehabilitation) Facility.
- Reimbursement for travel and lodging for both the patient (subscriber) and the companion will be made payable to the subscriber.
- Member cost-sharing responsibilities (copays/coinsurance/deductibles) do not apply to travel and lodging services. If a member elects to receive a non-covered service, he or she is responsible for the entire charge associated with the non-covered service.
- Travel and lodging do not count toward the maximum out-of-pocket cost limits.
- Travel and accommodation for follow-up visits from the member's home back to the transplant facility are excluded from this benefit.

|                                     |                            |
|-------------------------------------|----------------------------|
| <b>Member ID#</b>                   |                            |
| <b>Member Last Name</b>             | <b>Member First Name</b>   |
| <b>Member Street Address</b>        | <b>Member City</b>         |
| <b>Member State</b>                 | <b>Member Zip</b>          |
| <b>Member Date of Birth</b>         | <b>Sex</b>                 |
| <b>Names of Travel Companion(s)</b> | <b>Date(s) Accompanied</b> |

### Lodging

Please list your lodging expenses by date for the patient and applicable companion(s). Please note the exclusions listed at the end of this reimbursement form.

| Date(s) | Name of Establishment | Number of People | Total Dollar Amount | Receipt Included         |
|---------|-----------------------|------------------|---------------------|--------------------------|
|         |                       |                  |                     | <input type="checkbox"/> |
|         |                       |                  |                     | <input type="checkbox"/> |
|         |                       |                  |                     | <input type="checkbox"/> |
|         |                       |                  |                     | <input type="checkbox"/> |
|         |                       |                  |                     | <input type="checkbox"/> |

### Travel

Please include address from the patient's home and the transplant facility address. Mileage is reimbursed at the most current medical mileage rate at [www.IRS.gov](http://www.IRS.gov) and based on an objective source such as Google Maps/MapQuest. Tolls and parking fees the day of travel are eligible for reimbursement. Itemized receipts and itinerary (detailing where travel started/ended) for each individual trip required for the following modes of transportation: plane, bus, taxi, train, other. Airfare reimbursement is limited to coach or economy fares.

| Starting Location Physical Address |                           | Transplant Center Street Address |                     |
|------------------------------------|---------------------------|----------------------------------|---------------------|
|                                    |                           |                                  |                     |
| Date(s) Traveled                   | Name of Patient/Companion | Mode of Transportation*          | Total Dollar Amount |
|                                    |                           |                                  |                     |
|                                    |                           |                                  |                     |
|                                    |                           |                                  |                     |



Mail to: PO Box 21146 Eagan, MN 55121

Travel continued:

| Date(s) Traveled | Name of Patient/Companion | Mode of Transportation* | Total Dollar Amount |
|------------------|---------------------------|-------------------------|---------------------|
|                  |                           |                         |                     |
|                  |                           |                         |                     |

\*Method of travel: Plan, Bus, Taxi, Personal Vehicle, Train, Rideshare, Other (please specify and provide receipts for each ride)

| Date(s) | Tolls / Parking Fees | Receipt Included <input checked="" type="checkbox"/> |
|---------|----------------------|------------------------------------------------------|
|         |                      | <input type="checkbox"/>                             |
|         |                      | <input type="checkbox"/>                             |
|         |                      | <input type="checkbox"/>                             |

I certify that the above information is true, and the enclosed material is correct and unaltered, and the expenses were incurred by the patient and/or eligible companions. I understand all material submitted becomes the property of Univera Healthcare and will not be returned. I realize false receipt or fraudulent alterations of these materials may result in civil or criminal prosecution. I authorize the release of any information.

| Date(s) | Phone (including area code) | Signature |
|---------|-----------------------------|-----------|
|---------|-----------------------------|-----------|

- Original itemized receipts including all pertinent information must be submitted with this claim form when indicated that they are required.
- Cancelled checks, money orders, credit card vouchers and personal list of services or bills stating only "balance forward" are not acceptable.
- Make copies of the original receipts for your files before submitting the original. All materials submitted will be retained by us and cannot be returned to you.

**Exclusions include, but are not limited to:**

- |                                                   |                                  |                                           |
|---------------------------------------------------|----------------------------------|-------------------------------------------|
| ○ Alcoholic and tobacco products                  | ○ Household products             | ○ Postage                                 |
| ○ Car maintenance                                 | ○ Household utilities (i.e.,     | ○ Security deposits                       |
| ○ Car rental club memberships                     | maid, babysitter)                | ○ Telephone bills and cell phone charges  |
| ○ Cards, stationery, stamps                       | ○ Kennel fees and veterinary     | ○ Toiletries                              |
| ○ Clothing                                        | boarding fees                    | ○ Toys                                    |
| ○ Dry cleaning                                    | ○ Laundry services               | ○ Transportation that exceeds coach rates |
| ○ Entertainment (books, magazines, movie rentals) | ○ Meals are not included         | ○ Traveler check fees                     |
| ○ Extended Airport Parking                        | ○ Mileage within transplant city | ○ Valet Parking                           |
| ○ Flowers                                         | ○ Other personal items           |                                           |

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