Transplant RECIPIENT Travel Reimbursement Form

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

In order to receive reimbursement according to your benefits, please submit the following documentation:

- This **Transplant RECIPIENT Travel Reimbursement Form**, completed legibly and in its entirety.
- All receipts. These must be legible and match the information provided on this form.
- A log of miles traveled. Eligible travel reimbursement is provided only for travel of more than 60 miles.

See page 2 of this form for excluded expenses.

Donor expenses must be submitted separately using the Transplant DONOR Travel Reimbursement Form.

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

Name of subscriber:	**Transplant Member ID # :**	**Transplant Member date of birth:**
Transplant recipient name:	**Recipient's relationship to subscriber:** ☐ **Self** ☐ **Other**	**Transplant recipient email address:**
Traveling companion(s) name:	**Relationship of companion (s) to recipient:** ☐ **Spouse** ☐ **Other**	**Total number of receipts included:**
Member address:	**City, State, Zip:**	
Donor name (if known):		

Travel date(s) *travel date(s) **TO** the hospital facility*	**Travel date(s)** *travel date(s) **FROM** the hospital facility*	**Transportation** *air, bus, pre-approved rental car*	**Lodging** *Up to $200 per day for Recipient and for traveling Companion(s)*	**Personal Car Mileage** *††based on IRS rate for medical travel*	**Meals** *up to $75 per day for Recipient and for traveling Companion(s)**	**Total**
Ex: 9/5/2023		*$0*	*$175.55*	*$22.00*	*$46.75*	*$244.30*
Totals:	___					

††IRS mileage reimbursement rate for medical travel is published on the IRS website at www.irs.gov.
*Transplant Recipients are allowed one companion if the Recipient is an adult, or two Companions if the Recipient is under the age of 18

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 document 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; or if you are filing the claim on behalf of a Member who is over the age of 18, you must provide a Power of Attorney or Appointment of Representative. Signature must be legible to determine payment eligibility.*

For internal use only: Diagnosis Number: _____ Provider ID: _____

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Form Instructions

You must submit these documents within 6 months from the date the services were received, unless timely filing was prevented. Please be advised that it 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 transplant recipient
- The Member ID and home address
- The full name of the Member traveling companion(s)
- The place of service where the transplant occurred
- The date of each travel expense
- The description and/or charge for each daily travel expense incurred

Transplant services must be pre-authorized to receive travel reimbursement.

Exclusions and Specifications

The following are specifically excluded from reimbursement under any circumstances. Other expenses not listed below also may be denied if they are not preapproved.

a. Alcohol/tobacco/cannabis
b. Car, trailer, truck rental (unless pre-approved by the Centene Center of Excellence)
c. Vehicle maintenance (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.)
d. Parking (unless pre-approved by the Centene Center of Excellence)
e. Storage rental units, temporary housing incurring rent/mortgage payments
f. Loss of wages due to time off from work required for the transplant for Recipient, Donor or Companion(s)
g. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.
h. Speeding or parking tickets
i. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
j. Any services related to pet care, boarding, lodging, food, and/or travel expenses
k. Expenses for persons other than the Transplant Recipient, Donor, or their respective Companion(s)
l. Expenses for lodging the Transplant Recipient, Donor, or their respective Companion(s) are staying with a relative, friend, or otherwise have free lodging
m. Any expense not supported by a receipt
n. Upgrades to first class travel (air, bus, and train)
o. Personal care items (e.g., shampoo, deodorant, clothes)
p. Luggage or travel-related items including passport/passport card, REAL ID travel ids, travel insurance, travel agency fees, TSA precheck, and early check-in boarding fees, extra baggage fees
q. Souvenirs (e.g., t-shirts, sweatshirts, toys)
r. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type
s. All other items not described in the policy as eligible expenses
t. Any fuel costs/charging station fees for any vehicle
u. Any tips, concierge, club level floors, and gratuities
v. Salon, barber, and spa services
w. Insurance premiums
x. Cost share amounts owed to the transplant surgeon or facility or other provider

If you have questions regarding your benefits, please call the customer service telephone number listed on your Ambetter Health ID card or your transplant coordinator through the Center of Excellence. Send completed form to Ambetter Health Plan by mail **WITH RECEIPTS** and **MILEAGE LOG** attached. Please keep photocopies of your

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bills, receipts, and supporting documentation for your personal records.

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

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