Transplant Travel Reimbursement Form

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

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

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

+ The transplant travel benefit is limited to the evaluation, the trip to the transplant center for the transplant procedure (if this requires a separate trip from the evaluation trip), and the initial post-transplant period after discharge during the time the transplant program requires the transplant recipient 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 $150 limit per day for food & lodging for recipient and companion.** Toiletries, personal items, alcoholic beverages, and magazines are not covered.

+ **Food receipts must be itemized with items for the transplant recipient circled. 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 twelve (12) months of incurred expense to be eligible for reimbursement.**

+ **There is a $5000 maximum benefit for transplant travel.**

Transplant Recipient Information:

_____
TRANSPLANT RECIPIENT NAME

_____
TRANSPLANT RECIPIENT MEMBER ID

Date Range(s) for Reimbursement:

FROM ___/___/___ TO ___/___/___

☐ Initial Evaluation

☐ After discharge from transplant admit until released to return home

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Total reimbursement requested for lodging:

$ _____

_____
NAME OF HOUSING FACILITY/HOTEL

_____
ADDRESS

_____
ROOM OR APT #

_____ _____
CITY STATE

_____ ( ) -
ZIP PHONE NUMBER

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

Total reimbursement requested for food:

$ _____

(Attach itemized receipts)

Total reimbursement requested for transportation:
Mileage is reimbursed based on the medical transportation rate set by the Internal Revenue Service (IRS).

☐ Auto: Roundtrip miles for evaluation:
$ _____

☐ Auto: Roundtrip miles for transplant:
$ _____

☐ Plane or train from home to transplant center:
$ _____

Please submit receipts for tickets showing passenger name(s):

_____

_____

Reimbursement check to be sent to:

_____ _____ _____ _____
ADDRESS CITY STATE ZIP

_____ / /
SIGNATURE DATE