



## Transplant Recipient Reimbursement

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 within one year from date of travel\*:

- 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 75\* miles.

\* One year requirement will be waived if you or your covered dependent member had no legal capacity to submit such proof during that year.

\* \*This minimum mileage requirement varies by state. Check with your Care Coordinator to confirm the requirement for your plan.

See page 2 of this form for instructions and a list of excluded expenses.

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

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

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<b>Name of Subscriber/member:</b>	<b>Member ID:</b>	<b>Member DOB:</b>
<b>Transplant recipient name:</b>	<b>Recipient's relationship to the subscriber/member:</b> Self or other	<b>Relationship of companion or caregiver* to recipient:</b> Spouse or Other
<b>Traveling companion/ caregiver name:</b>	<b>Transplant recipient email:</b>	<b>Total number of receipts:</b>
<b>Donor address (City, State, Zip):</b>		

\*Traveling companion or caregiver is limited to a parent, spouse, child, sibling, or significant other with the transplant donor.

**EXPENSE AND MILEAGE LOG**

<b>Travel dates(s) TO facility</b>	<b>Travel date(s) FROM facility</b>	<b>Transportation</b> Air, bus, pre-approved rental car	<b>Lodging</b>	<b>Personal Care Mileage</b>	<b>Meals</b>	<b>Total</b>

*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 have to pay money back or face legal actions.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please Note:** A signature is required by the donor or companion. If you are filing the claim on behalf of a recipient who is over the age of 18, you must provide a Power of Attorney or Appointment of Representative. Signature must be legible to process request.

## 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 recipient
- The recipient home address
- The full name of the recipient's traveling companion
- 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 pre-authorized.

- Child care
- Mileage for travel while within the facility city
- Rental cars, buses, taxis, or shuttle service, except as pre-authorized
- Frequent flyer miles
- Coupons, vouchers or travel tickets
- Prepayments or deposits
- Telephone calls
- Laundry
- Postage
- Entertainment
- Interim visits to a medical care facility while waiting for the actual transplant procedure
- Travel expenses for recipient companion/caregiver
- Return visits for the recipient for a treatment of a condition found during the evaluation

Send this completed form to CareSource by mail **WITH RECEIPTS and MILEAGE LOG** attached. Please keep photocopies of your bills, receipts, and supporting documentation for your personal records.

### CareSource

Attn: Claims Department – Member Reimbursement  
P.O. BOX 3607  
Dayton, OH 45401-3607

*Qualified Health Plans offered in North Carolina by CareSource North Carolina Co., d/b/a CareSource.*