CareSource
Health Care with Heart

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):

_____

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

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

EXPENSE AND MILEAGE LOG

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

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

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