Transplant DONOR Reimbursement

Thank you for donating the gift of life. Our team is ready to help you receive the appropriate benefits for your transplant donation related expenses.

CareSource plans include reimbursement for certain covered services when the living Transplant Donor must travel more than 75 miles or more one way. To receive reimbursement, please submit the following documentation within one year from date of travel:

- **Transplant DONOR Travel Reimbursement Form** – complete this form legibly and in its entirety.
- **All receipts** – Include itemized receipts that are 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 way.

* 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 health plan.

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

Recipient expenses must be submitted separately using the Transplant RECIPIENT Travel Reimbursement Form.

If you need help reading or completing this form, please contact Member Services at **1-877-514-2442** (TTY: 711). Our hours are 8 a.m. to 5 p.m. Central Time (CT), Monday through Friday.

Transplant Center (Facility Name): _____

Facility Location (City, State): _____

DONOR First Name:		**Date of Birth:**
DONOR email address:		**Total number of receipts:**
Traveling companion/ caregiver name:	**Relationship of companion or caregiver* to DONOR:** ☐ Spouse or ☐ Other	
Street 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 date(s) TO facility	**Travel date(s) FROM facility**	**Transportation** Air, bus, pre-approved rental car	**Lodging**	**Personal Car 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 form. Signature must be legible to process request.*

Transplant Donor Travel Reimbursement
Form Instructions

Submit the required documents within one year from the date the services were received. Please be advised that it may take up to 60 days to process your request.

Complete all applicable sections on the form:

- Full name of the transplant donor and date of birth
- Donor home address and email address
- Full name of the donor's traveling companion
- Transplant Center facility name and address (City, State)
- Date of each travel expense
- Description and/or charge for each daily travel expense incurred

Transplant services must be pre-authorized and one-way distance must exceed 75 miles to qualify for travel reimbursement.

Exclusions and Specifications

The following are specifically excluded from reimbursement without exception. 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
- Return visits for the recipient for a treatment of a condition found during the evaluation

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

CareSource
Attn: Claims Department – Member Reimbursement
P.O. Box 1305
Dayton, OH 45401-1305

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