



Transplant RECIPIENT Reimbursement

Thank you for being a member of CareSource. We understand that this is a difficult time for you and your family. We want you to know that our team stands ready to help you receive the appropriate benefits for your transplant-related expenses.

To receive reimbursement for transplant recipient travel, as detailed in your plan benefits, please submit the following documentation within one year from date of travel*:

- **Transplant RECIPIENT 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.

Donor expenses must be submitted separately using the Transplant DONOR 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): _____

| | | |
|---|---|----------------------------------|
| Subscriber Name: | Relationship to Transplant Recipient: Self or Other (Please specify): | |
| Transplant recipient name: | Member ID: | Member Date of Birth: |
| Transplant recipient email: | | Total number of receipts: |
| Traveling companion/ caregiver name: | Relationship of companion or caregiver* to recipient: Spouse or Other | |
| 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 date(s) TO facility | Travel date(s) FROM facility | Transportation Air, bus, pre-approved rental car | Lodging | Personal Car Mileage | Meals | Total |
|----------------------------|------------------------------|---|---------|----------------------|-------|-------|
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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 Recipient 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 recipient, member ID and date of birth
- Recipient home address
- Full name of the recipient'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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