



TRAVEL AND LODGING REIMBURSEMENT FORM FOR TRANSPLANT RELATED EXPENSES

We understand that this is a difficult time for you and your family. Blue Cross Medicare Advantage of IL, TX, OK, NM and MT stands ready to help guide you, so you receive appropriate reimbursement for your transplant related expenses.

To receive reimbursement according to your benefits, we request you complete, although not a requirement, this form which documents your travel and lodging expenses for faster processing. It is required though that you include legible receipts to obtain the benefit. Please submit legible receipts along with this Travel and Lodging Reimbursement form which must match the information documented in sections of the form.

Mail the form along with original receipts to:

Blue Cross Medicare Advantage (Claims)
PO Box 3686
Scranton, PA 18505

SECTION 1

Please note: One companion or caregiver is allowed for a patient/member. A companion or caregiver is one that accompanies the patient or a person who provides direct care to the patient.

Member Name:	Subscriber ID:
Home Street Address:	City, State, and Zip:
Patient date of birth:	Telephone Number:
Companion/Caregiver Name:	Dates Accompanied:

Section 2

In Section 2, please list your lodging expenses by date for the patient and applicable companion or caregiver. Please note that the receipt for lodging items documented below must be included with this form.

Lodging Receipts Reimbursement based on receipts for sleeping accommodations for only those listed in Section 1 of this form, including tax and tip.

Date (s)	Name of Hotel /Motel/Temp Residence	Address	Total Dollar Amount for Reimbursement

Section 3

Please include addresses from the patient's home, (can also include temporary residence address when applicable), to the transplant facility. Gasoline receipts will be required if reimbursement is requested.

Patient Home Address	Transplant Facility Address	Dates Traveled Home to Facility	Dates Traveled Facility to Home

Section 4

Miscellaneous

Please list miscellaneous services or expenses not already addressed in the above sections.

Please note: Reimbursement is based on receipts for those listed in Section 1 on this form according to your benefits.

Date(s)	Name of Service or Expense	Total Amount of Expense or Service

<HMO plan in New Mexico, HMO and HMO-POS plans in Illinois, and PPO plans in Illinois, Montana, and New Mexico are provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HMO plan in Illinois provided by Illinois Blue Cross Blue Shield Insurance Company (ILBCBSIC). HMO Special Needs Plan and PPO Special Needs Plan in New Mexico provided by HCSC. HMO, PPO, and Dual Care HMO Special Needs plans in Texas provided by HCSC Insurance Services Company (HISC). PPO plan in New Mexico provided by HISC. HMO and PPO plans in Texas provided by GHS Insurance Company (GHSIC). All HMO and PPO employer/union group plans provided by HCSC. HMO plan in Oklahoma provided by GHS Health Maintenance Organization, Inc. d/b/a BlueLincs HMO (BlueLincs). HMO Special Needs Plan and PPO plans in Oklahoma provided by GHS Insurance Company (GHSIC). HCSC, ILBCBSIC, HISC, GHSIC, and BlueLincs are Independent Licensees of the Blue Cross and Blue Shield Association. ILBCBSIC, GHSIC and BlueLincs are Medicare Advantage organizations with a Medicare contract. HCSC is a Medicare Advantage organization with a Medicare contract and a contract with the New Mexico Medicaid program. GHSIC is a Medicare Advantage organization with a Medicare contract and a contract with the Oklahoma Medicaid program. HISC is a Medicare Advantage organization with a Medicare contract and a contract with the Texas Medicaid program. Enrollment in these plans depends on contract renewal.>