Medical Travel Reimbursement Form

If you are unable to locate an in-network provider within 50 miles of your home, you may be eligible for reimbursement of certain expenses incurred for travel to the nearest in-network provider within 300 miles from your home.

Prior authorization is required; please contact Customer Service by calling the phone number listed on the back of your member ID card. Not all plans include coverage for Medical Travel Reimbursement. Please refer to your member handbook, contract, or summary plan description. If you are unable to locate an in-network provider within 50 miles of your home, you may be eligible for reimbursement of certain expenses incurred for travel to the nearest in-network provider within 300 miles from your home.

Please keep a copy of all items submitted.

Please Note

+ Not all expenses are eligible for reimbursement. Examples of some services not eligible for reimbursement include bus, plane, or train tickets; personal items, toiletries, alcoholic beverages, magazines, etc.
+ Receipts are required for all reimbursement, with the exception of mileage.
+ Mileage reimbursement is limited to a maximum of 300 miles each way and is reimbursed at the IRS medical transportation reimbursement rate.
+ Parking fees are not covered unless part of hotel charges.
+ Food receipts must be itemized with items for the member circled.
+ Lodging receipts must be itemized on hotel/lodging facility receipt or contract.
+ Services may be subject to the deductible before the plan reimburses for travel expenses.
+ Reimbursement is limited to a maximum of $1,500 per calendar year.
+ Daily expenses for food and lodging are limited to $150 per day only when an overnight stay is required.

Complete the form on the following page, attach appropriate receipts, and mail to:

Providence Health Plans
ATTN: Claims
P.O. BOX 3125
Portland, OR 97208-3125

Patient Information:

FULL NAME

MEMBER ID

Date(s) of service(s):

FROM __ __/__ __/__ __ TO __ __/__ __/__ __

FROM __ __/__ __/__ __ TO __ __/__ __/__ __

FROM __ __/__ __/__ __ TO __ __/__ __/__ __

Total reimbursement requested for lodging:

$

NAME OF HOUSING FACILITY/HOTEL

ADDRESS

ROOM OR APT #

CITY STATE

ZIP PHONE NUMBER

Total reimbursement requested for transportation:

$

(Attach receipts)

ADDRESS OF STARTING POINT

ADDRESS OF DESTINATION

ROUNDTRIP MILEAGE FOR CONSIDERATION

Total reimbursement requested for food:

$

(Attach itemized receipts. Benefit for member only.)

Please submit verifiable contract or receipt along with # of guests. Some items are not eligible for reimbursement, including but not limited to: refundable deposits, furnishing rental/purchases, and phone charges. Benefit covers member only.

Reimbursement check to be sent to:

ADDRESS CITY STATE ZIP

SIGNATURE DATE