Gene Therapy & Adoptive Cellular Travel Reimbursement Form

Providence Health Plan

Please fill in the form below, attach appropriate receipts, and mail to:
Providence Health Plans, Travel Claims, Suite T, PO Box 4327, Portland, OR 97208-4327

Please keep a copy of all forms and other items submitted and check your member contract for exact benefits.

- Reimbursement covers the recipient plus one travel companion.
- Benefits are not available during the time the recipient is receiving the procedure.
- Receipts are required for all reimbursement, with the exception of mileage reimbursement if you are traveling by automobile.
- **There is a $300 limit per day for food & lodging for recipient.** Toiletries, personal items, alcoholic beverages, and magazines are not covered.
- **Food receipts must be itemized by circling the recipient and companion's items. Lodging receipts must be itemized and on hotel/property management letterhead.** Parking fees not covered unless part of hotel charges.
- Automobile-related reimbursement is based on the roundtrip mileage from your home to the transplant center and reimbursed per the federal mileage reimbursement for personal cars being driven for medical purposes.
- Receipts must be submitted within 12 months of incurred expense to be eligible for reimbursement.
- Medical deductible applies to the maximum travel reimbursement travel limit. **There is a $7,500 limit per calendar year.**

Recipient Information:

_____
RECIPIENT NAME

_____
RECIPIENT MEMBER ID

Date Range(s) for Reimbursement:

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

☐ Initial / Pre-surgical evaluation(s)
☐ Trip to procedure
☐ Follow-up visit

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Total reimbursement requested for lodging:

$ _____

_____
NAME OF HOUSING FACILITY/HOTEL

_____
ADDRESS

_____
ROOM OR APT #

_____ _____
CITY STATE

_____ ( ) -
ZIP PHONE NUMBER

Total reimbursement requested for food:

$ _____

(Attach itemized receipts)

Total reimbursement requested for transportation:
Reimbursements are based on date of service and Federal reimbursement rates

☐ Auto: Roundtrip miles for evaluation:
$ _____

☐ Auto: Roundtrip miles for procedure:
$ _____

☐ Plane or train from home to procedure location:
$ _____

Please submit receipts for tickets showing passenger name:

_____

_____

Please submit verifiable contract or receipt. Some items are not eligible for reimbursement including refundable deposits, furnishing rental/purchases, and phone charges.

Reimbursement check to be sent to:

_____ _____ _____ _____
ADDRESS CITY STATE ZIP

_____ __/__/__
SIGNATURE DATE

DISCLAIMER: This benefit is subject to the coverage described in your medical benefit plan and is reimbursable up to any identified limits, after deductible. However, certain portions of this travel benefit may not fall within the IRS definition of "medical care," for tax purposes. Please consult with your employer benefits team to determine if using portions of these benefits could have tax-related impacts for you. If you have a high deductible health plan, you should contact your HSA vendor for any questions regarding what specific costs can be paid for using your HSA account. Providence Health Plan is not responsible for any employer and/or employee tax considerations, obligations, and/or impacts as may relate to specific plan benefits offered within your plan.