SAIF
Transplant Travel Reimbursement Form

Administered by Providence Health Plan

Please fill in the form below, attach appropriate receipts, and mail to:
Providence Health Plans, Transplant 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.

- The transplant travel benefit is limited to services provided to the member:

  (1) The evaluation; (2) the trip to the transplant center for the transplant procedure (if this requires a separate trip from the evaluation); and (3) the initial post-transplant period after discharge, during which the transplant recipient is required to remain in the local area of the transplant facility.
- Per your member contract, the benefit applies to the transplant recipient only.
- 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 are required for all reimbursement, with the exception of mileage reimbursement if you are traveling by automobile. Combined daily expenses for food & lodging are limited to $300/day maximum:**
  - Food receipts must be itemized by circling the transplant recipient's items.
  - Lodging receipts must be itemized and on hotel/property management letterhead.
  - Toiletries, personal items, alcoholic beverages, and magazines, etc., are not covered.
- Medical deductible applies to the maximum transplant travel reimbursement travel limit.
- **Maximum transplant travel reimbursement is $5,000 per transplant.**
- Receipts must be submitted within 12 months of incurred expense to be eligible for reimbursement.

Transplant Recipient Information:

_____
TRANSPLANT RECIPIENT NAME

_____
TRANSPLANT RECIPIENT MEMBER ID

Date Range(s) for Reimbursement:

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

- ☐ Initial / Pre-surgical evaluation(s)
- ☐ Trip to transplant center for transplant 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 transplant:
$ _____

☐ Plane or train from home to transplant center:
$ _____

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.