Reimbursement Form:
Medicare Transplant Transportation and Lodging

BlueCross BlueShield Minnesota

Transportation and lodging for the recipient and one (1) companion may be eligible for reimbursement. This form may be used for reimbursement of expenses as the result of a Medicare-approved transplant.

The reimbursement form provides information about the Medicare Transplant Transportation and Lodging benefits. Final eligibility and coverage determinations are made at the time Blue Cross and Blue Shield of Minnesota processes your claim and will be based on the transplant type and transplant facility used and will be subject to plan maximums.

To process your claim, we need you to include all the information requested on this form.

- Requests may be submitted after the costs have been incurred
- Claims must be submitted within 12 months of incurred expense
- Itemized Receipts are **required** for lodging, transportation, parking fees and tolls (credit card statements are not an eligible receipt)
- Receipts **not required** for personal car mileage
- Incomplete forms may result in payment delay
- Please make a copy for your personal files because we cannot return the documents that you send

Send completed form and receipts by mail:

Blue Cross and Blue Shield of Minnesota
PO Box 982805
El Paso, TX 79998-2805

The information below contains some eligible expenses and applicable limits, but please see your Evidence of Coverage for a full description of your benefits.

Description	Benefit
Lodging	Reimbursement expenses are based on IRS per diem rates for that year.
Transportation	Applies to the patient and one companion who are traveling on the same day(s) to and from the patient's residence and the provider for the purpose of an evaluation, the service, or necessary post-service follow-up. • Includes travel by air, bus, rail, or ground transportation • Includes parking fees and tolls • Personal car mileage reimbursement rate is the IRS medical mileage allowance in effect on the dates of travel. • If traveling by air, bus or rail, the reimbursement amount will be the lessor of: 1) travel fare purchased **or** 2) mileage between the patient's residence and the provider's location per an on-line mileage calculator.
Exclusions	Non-covered expenses include, but are not limited to, international travel, meals, gas, utilities, childcare, security deposits, cable hook-up, dry cleaning, laundry, pet care, car rental fees and personal items.
Questions	Call the customer service number on the back of your member ID card.

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Patient Information			
Subscriber's Last Name	Subscriber's First Name	Subscriber's Birthdate	Patient Gender ☐ M ☐ F ☐ U
Subscriber's Street Address	City	State	Zip Code
Identification Number	Group Number	Patient Phone Number	

Provider Information (Required)				
Type of Transplant	Transplant Facility & Phone Number	Address	City, State	Zip Code

Transplant Procedure Information (Required)			
Date(s) of Services / Procedure			
Type of Care: ☐ Pre-Transplant	☐ Transplant Admission	☐ Post-Transplant	
Please provide any dates the patient was inpatient during this time.	From:	To:	

Lodging (itemized receipts are required)				
Date(s)	**Location**	**Number of Nights**	**Rate including tax**	**Total**
				$ 0.00

Transportation

Number of trips from the patient's residence to facility location and or facility location to patient's residence with personal vehicle. (Receipts not required)

Date(s)	From address	To address

Airfare/Bus/Rail/Ground Transportation (Itemized receipts are required.)

Date(s)	To	From	Ticket Price

Parking Fees and Tolls (Itemized receipts are required.)

Date(s)	Total

I certify the charges I am submitting for reimbursement are eligible and were incurred for transplant care. I also understand that reimbursed expenses are not tax deductible. I hereby certify that the statements provided by me are correct and acknowledge that I will refund Blue Cross and Blue Shield of Minnesota duplicate payments to myself from other sources because of coordination of benefits.

Note: A person who files a claim with the intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

☐ **I understand that typing my name in the line below constitutes a legal signature.**

Signature **Date**