BlueCross BlueShield of Alabama

INSTRUCTIONS FOR FILING A TRAVEL BENEFIT CLAIM

Please read all instructions carefully before completing the Travel Benefit Claim Form. In order to submit a travel claim, your employer plan must have a travel benefit option. This form should not be used for transplant travel services. For transplant travel services, please reach out to our Care Management team at 1-800-821-7231 or HMTRANSPLANT@bcbsal.org.

This form is needed to submit claims for covered travel services to the nearest in-network provider who can treat your condition.

1. After you have returned from travel for legally covered healthcare services, complete all sections of this form.
2. Please complete the itemized expense listing at the end of this form.
3. If you have primary insurance with another carrier that covered the healthcare services received by the patient, please provide a copy of your ID card(s) and send a copy of your EOB statements from the primary insurance company for the claim you are submitting (i.e., Medicare, Health, Auto or Workman's Comp).
4. Copy your itemized travel receipts that show proof of travel and payment. Please include:
   - All transportation receipts, including, but not limited to, boarding pass and detailed itinerary (name, date and payment method). This may include airfare, rental car, tolls, fuel, parking, bus, and taxi/ Uber as appropriate for the distance and need. Please check your benefit booklet or contact customer service for details regarding reimbursable expenses under your plan.
   - Lodging receipts

DOCUMENTS MUST INCLUDE:

- Name of traveler(s)
- Dates and total cost of travel (lodging expenses will be paid in alignment with the IRS regulations. Please check your benefit booklet or contact customer service for details.)

REIMBURSEMENT MAY BE DELAYED IF:

- All the above information is not included
- Travel documents are modified (e.g., using a marker to highlight any information)
- EOBs or claims for the associated covered service have not been received

Please be sure to review your claim form and documents carefully to ensure we can process your claim accurately and quickly. Please keep a copy of all documents provided.

Please mail your completed claim form with receipts and copies of the other EOBs, if applicable to:

Blue Cross and Blue Shield of Alabama Claims Department
P.O. Box 995
Birmingham, Alabama 35298-0001
Fax 1-205-220-2146

CONTINUE

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TRAVEL BENEFIT CLAIM FORM

CONTRACT HOLDER INFORMATION (the policy holder name shown on the front of your ID card)

Contract Holder's Legal Name (Last, First, Middle Initial)		
Last	First	Middle Initial

Contract Number (as shown on your I.D. card)	Group Number	Employer Name (if applicable)

PATIENT INFORMATION

Patient's Legal Name (Last, First, Middle Initial)			Date of Birth (MM/DD/YYYY)
Last	First	Middle Initial	

Patient's Gender	Patient Relationship to Insured
☐ Male ☐ Female	☐ Self ☐ Child ☐ Spouse ☐ Other (explain)

Patient's Address	City	State	Zip Code

Travel Companion Name	What was the covered service that necessitated travel?	Date of Covered Service

Claim Number of covered service in which you traveled for from EOB	Provider Name		Provider Phone	
	Last	First		
	Address	City	State	Zip Code

OTHER HEALTH INSURANCE

Does the Patient have primary coverage from another health plan?

☐ No Skip this section ☐ Yes Please attach the Explanation of Benefits (EOB) from the primary plan with this claim & complete the information below

Name of Policyholder (Last, First, Middle Initial)		
Last	First	Middle Initial

Policy Number	Effective Date *(MM/DD/YYYY)*	Name of Insuring Company	Carrier Phone Number

AUTHORIZATION AND SIGNATURE REQUIRED

I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above and outlined per my travel benefits. In addition, I understand and attest to the following:

- The healthcare services I traveled to receive are legally covered services under my benefit plan. If the services are not legally covered services, then I understand that travel is not a covered benefit.
- The healthcare services I traveled to receive were not available within the mileage radius as designated in my benefit booklet from an in-network provider.
- I received the healthcare services from the closest provider I could locate.
- Benefits will be paid according to my benefit booklet and is limited based on the IRS pre-tax health care guidelines and will only cover travel and lodging.
- Excluded Services including, but not limited to food, drinks, clothing, laundry/dry cleaning, entertainment, household products, or animal/kennel fees as outlined in my benefit booklet.
- I have followed the rules for travel based on my company's guidelines.
- I understand that additional information may be requested from me to confirm that travel meets the criteria for reimbursement under my health benefit plan.
- I understand that coverage is provided under this plan are pursuant to applicable laws and are limited to those services, supplies and/or drugs that may be legally performed, prescribed or dispensed by a licensed health care provider, supplier or pharmacy.

Signature of Policy Holder	Date (MM/DD/YYYY)

CONTINUE

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TRAVEL BENEFIT CLAIM FORM

ITEMIZED EXPENSES

Please include the date and total reimbursement requested for each expense type.

- Not all submitted receipts may be covered.
- Please contact customer service or check your benefit booklet for a list of covered items.

	DATE OF EXPENSE					
	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Expense Date						
Lodging						
Airfare						
Airport (parking & tips)						
Taxi/Bus/Train						
Rental Car						
Tolls/Parking						
Other*						
Total of all expenses by date	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

Other* *(Please contact customer service or check your benefit booklet for a list of covered items.)*

Description	Expense Total