Transplant Benefit Reimbursement Form

SANFORD HEALTH PLAN

Please complete this form, printing clearly, and return it to Sanford Health Plan to be processed. Member signature is required – see step 3 below. This form is to be used for requesting reimbursement for travel expenses paid out of pocket by the member in order to obtain an approved transplant procedure. Eligibility for travel-related reimbursement is dependent upon the distance traveled to receive approved transplant services, and the enrollee's benefit plan.

Step 1 - Member Information

Enrollee ID (on your member ID card)	Enrollee Name	
Patient Name		Patient Date of Birth
Patient Address	City	State/Zip Code
Transplant Procedure		Date of Procedure
Approved Transplant Facility		Prior Authorization #
Approved Transplant Facility Address	City	State/Zip Code

Step 2 - Details of Request

For what expenses are you requesting reimbursement? *Check all that apply:*

☐ Lodging ☐ Meals ☐ Travel (round-trip mileage from home to facility)

For who are you seeking reimbursement? *Check one:*

☐ Transplant Recipient Only ☐ Transplant Recipient + 1 Companion ☐ Transplant Recipient + 2 Parents*

Note: A transplant recipient may request reimbursement to cover expenses of one (1) travel companion.
**If a transplant recipient is a minor (i.e., age 19 years or younger) reimbursement may be requested to cover expenses of up to two (2) parents.*

Please fill in the blanks below, to the best of your knowledge, if applicable.

Travel Dates	Start:	End:
Type of Care	☐ Pre-transplant ☐ Transplant Admission ☐ Post-transplant	
Inpatient Dates	Start:	End:

Note: Meal expenses are not reimbursable during inpatient dates of service for transplant recipient.

Step 3 - Signature and Date

By submitting this form, I hereby certify that the charges submitted for reimbursement are eligible and have occurred as part of transplant care. I understand that reimbursed expenses are not tax deductible and are based on Federal IRS per diem rates for the applicable year, and that all requests must be submitted within 6 months of incurred expenses.

X _____ _____

Signature Date

Step 4 - Instructions for Submitting this Form

Completed forms shall be sent to Sanford Health Plan through one of the following options.

Mail to: Sanford Health Plan ATTN: Claims PO Box 91110 Sioux Falls, SD 57109-1110	**OR**	**Email to:** healthplanclaimsfax@sanfordhealth.org Subject: Member Travel Reimbursement	**OR**	**Fax to:** (605) 328-6840 ATTN: Claims

If you have questions about this form, please call Sanford Health Plan's customer service team at (800) 752-5863 (TTY: 711) from 8 a.m. to 5 p.m. CST Monday through Friday for more information.

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