Transplant Benefit Reimbursement Form

SANFORD HEALTH PLAN

- Please complete this form, printing clearly
- Return it to Sanford Health Plan to be processed (see step 4 below)
- 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
- **You are not required to submit receipts for the travel expenses incurred.**

Step 1: MEMBER INFORMATION

Enrollee ID (on your member ID Card)	Enrollee Name		
Patient full 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 whom are you seeking reimbursement? *Check <u>only one</u>:*

☐ **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., under the age of 18) reimbursement may be requested to cover expenses of up to two (2) parents.*

Please fill in the items below to the best of your knowledge, if applicable. If you have multiple round-trips, please report each trip as a separate travel date/range. Utilize the additional comments section below or submit on a separate sheet if needed

Travel Dates (MM/DD/YYYY) Start _____ End _____

Type of Care ☐ Pre-Transplant ☐ Transplant Admission ☐ Post-Transplant

Inpatient Dates (MM/DD/YYYY) Start _____ End _____

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

Provide any additional comments or details here:

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.

_____ _____

SIGNATURE DATE

Step 4: INSTRUCTIONS FOR SUBMITTING THIS FORM

Return the completed form to Sanford Health Plan through one of these 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. CT Monday through Friday for more information.