Travel Reimbursement Form

This form is used to submit claims directly to Blue Shield of California for travel reimbursement. Please note that this form is to be used only for **travel expenses that have been identified as a reimbursable expense under your health plan**. Duplicate claims will not only be rejected but may delay payment of the original claim. Please include a clear, readable copy of all relevant receipts. If you have questions please call the Customer Service number on your Blue Shield ID card, or call **(877) 655-2583**.

Submit travel claim with receipts to :
Blue Shield of California, P.O. Box 272540, Chico, CA 95927-2540
Or Fax 248-733-6331

Please select the type of travel reimbursement. Coverage is identified as a reimbursable expense under your health plan:

- ☐ Bariatric
- ☐ Family Planning and/or Infertility
- ☐ Gender Reassignment
- ☐ Pregnancy Termination (requires a claim on file for services or documentation showing proof that services were rendered) ☐ Documentation of services included
- ☐ Transplant
- ☐ Other ________________________________

Travel receipts should include:	Travel exclusions:
• Date(s) of service • Mileage • Taxi / Ride Share Receipts • Airline Receipts • Hotel Receipts • Food Receipts • Total charges • Identification of companion charges	• Tobacco, alcohol, drugs, phone charges, television, recreation, and personal expenses. • Premium economy, business, or first-class airfare. • Limousine and car services. Taxi and ride share is allowable. • Expenses reimbursed by another source (e.g., employer or non-profit).

NAME, ADDRESS OF SUBSCRIBER AND PROCEDURE DETAILS

Subscriber Number:	Subscriber Group Number:
Subscriber Name:	
Mailing Address:	
City:	State and Zip:
Patient Name:	Date of Birth: (mm/dd/yyyy)
Relationship to Subscriber: (Self, child, spouse)	Gender:
Medical Procedure:	Date of Procedure:
Performing Physician:	Location of Procedure:

REIMBURSEMENT OF TRAVEL COSTS (check all that apply - when applicable - must be a reimbursable expense under your health plan)

☐ Transportation for member and companion if applicable (airfare, uber, etc).	Amount:
☐ Transportation Personal Mileage	Total Miles Round Trip:
Location From:	Location To:
☐ Hotel Accommodations	Amount:
☐ Meals for patient and companion if applicable	Amount:
☐ Additional Companion Expense	Amount:
Travel Reimbursement Total:	

By submitting this form, I am certifying that I had to travel to access these services; and the travel expenses included on this claim form were necessary for my travel. I certify that the foregoing information is accurate and complete, and authorize the release of any medical information necessary to process this claim:

Signature of participant | Date