



# 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 \_\_\_\_\_

<p><b>Travel receipts should include:</b></p> <ul style="list-style-type: none"> <li>• Date(s) of service</li> <li>• Mileage</li> <li>• Taxi / Ride Share Receipts</li> <li>• Airline Receipts</li> <li>• Hotel Receipts</li> <li>• Food Receipts</li> <li>• Total charges</li> <li>• Identification of companion charges</li> </ul>	<p><b>Travel exclusions:</b></p> <ul style="list-style-type: none"> <li>• Tobacco, alcohol, drugs, phone charges, television, recreation, and personal expenses.</li> <li>• Premium economy, business, or first-class airfare.</li> <li>• Limousine and car services. Taxi and ride share is allowable.</li> <li>• Expenses reimbursed by another source (e.g., employer or non-profit).</li> </ul>
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## 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)**

<input type="checkbox"/> Transportation for member and companion if applicable (airfare, uber, etc).	Amount:
<input type="checkbox"/> Transportation Personal Mileage	Total Miles Round Trip:
Location From:	Location To:
<input type="checkbox"/> Hotel Accommodations	Amount:
<input type="checkbox"/> Meals for patient and companion if applicable	Amount:
<input type="checkbox"/> 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