

Related Travel Expenses for Transportation Reimbursement Request Form

Promise Health Plan

Use this form to request reimbursement for eligible Related Travel Expenses for Transportation. Please provide the information requested below. If you have any questions, please call the Customer Care number on your Blue Shield Promise ID card.

Member/Donor Information

First Name	Last Name		
Subscriber ID (if Member) or Social Security Number (for non-member)			
Date of Birth			
Address			
City	State	ZIP	
Phone Number			
Email Address			

Attendant (Aide) Information (if applicable)

First Name	Last Name		
Subscriber ID (if Member) or Social Security Number (for non-member)			
Address			
City	State	ZIP	
Phone Number			
Email Address			

Service Information

Name and phone number of the doctor who performed the service:			
Purpose of visit (choose all that apply): Consultation Treatment Surgery Follow-up Pre-op Post-op			
Date(s) of service:			
Did you have an attendant (aide)?			
Was attendant approved by your doctor? If you have a signed note from the ordering doctor, please provide a copy yes no			
Travel Duration: Start Date End Date			

Provide all receipts for every day reimbursement is being requested. Reimbursement will be provided up to the maximum daily IRS amount per person. If mileage reimbursement is approved, reimbursement is based on the IRS medical mileage rate.

Transportation (if applicable): Mileage:	
Total Due for Attendant	-
Parking:	
Total Due for Member/Donor	Total Due for Attendant
Tolls:	
Total Due for Member/Donor	Total Due for Attendant
Other:	
Total Due for Member/Donor	
Lodging (if applicable):	
Total Due for Member/Donor	Total Due for Attendant
Meals (if applicable):	
Total Due for Member/Donor	Total Due for Attendant
Other (if applicable):	_
Total Due for Member/Donor	Total Due for Attendant
Member/Donor Signature:	
Please check if you are a parent/guardian of a r	ninor.
Member/Donor Print Name:	Date:
Submit this form and all receipts to:	
Attn: Reimbursement Dept.	
3840 Kilroy Airport Way	
Long Beach, CA 90806	
Fax: 323.889.5049	
Attn: Reimbursement Dept.	

Blue Shield of California Promise Health Plan is contracted with L.A. Care Health Plan to provide Medi-Cal managed care services in Los Angeles County. You can get this document for free in other formats, such as large print, braille, or audio. The call is free. Medi-Cal (Los Angeles) Customer Care: **(800) 605-2556 (TTY: 711)**, 8:00 a.m. to 6:00 p.m., Monday through Friday. Medi-Cal (San Diego) Customer Care: **(855) 699-5557 (TTY: 711)**, 8:00 a.m. to 6:00 p.m., Monday through Friday.

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