blue california

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:	Patient Social Security Number:
Subscriber's 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 patient 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 checking this box, I understand that any travel reimbursement expense may be tax reportable. The patient's SSN is required for tax reporting purposes. Reimbursements that do not include the patient's SSN will not be processed.

By submitting this form, I am certifying that I had to travel to access these services; and that 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 Patient. A parent/guardian may sign on behalf of a minor patient. Date