

Name: _____

Date of Birth: _____

Member ID: _____

Referral Number: _____

University of Utah Healthtravel Reimbursement Benefit: Policy Statement and Criteria

U of U Health Plans will reimburse approved travel-related expenses, if a benefit exists, at a maximum of \$10,000 a year in the following circumstances:

- A. Prior-authorization obtained prior to incurring any approvable travel-related expenses;
- B. Travel is to the University of Utah/Huntsman Cancer Institute, and requires travel from out of state or is located more than 120 miles from the patient's residence;
- C. Original receipts must be submitted with any claim;
- D. Eligible maximum reimbursement limits include the following (i - vi):
 - i. Travel reimbursements covers the member and one companion;
 - ii. Lodging/Meals: One room per day with a maximum reimbursement of \$200 per day including meals, including tax;
 - iii. Mileage by personal (not rental) vehicle at \$0.545 per mile; with route map and distance provided;
 - iv. Rental car reimbursement will be for the cost of rental plus applicable gas;
 - v. Reimbursement for a bus, shuttle or medically necessary taxi trips to and from the airport, facilities, and/or place of lodging are limited to \$50 per ride;
 - vi. Air/train/destination bus/ rental car travel reimbursement is at a maximum of \$1000 per person per trip.

Travel-related Expenses Excluded from Coverage include the following:

- If member is referred to an approved facility within 120 miles of their home and they choose a facility farther than 120 miles, member will not be reimbursed;
- If the member does not receive prior authorization, the Service and related expenses, including pre-transplant evaluation, will not be covered;
- Any Service specifically excluded under the member's health care benefits plan, except as otherwise provided in this section;
- In circumstances where a scheduled Service is not performed, except where the failure is beyond the member's control, expense-related costs are not eligible;
- Travel-related expenses incurred while patient is undergoing Non-Covered Services;
- Travel-related expenses incurred during Services provided under any private or public research



Utah Travel Reimbursement Benefit Form (1 of 2)

Name: _____
 Date of Birth: _____
 Member ID: _____
 Referral Number: _____

Dates of service- Appointments and/or procedures _____

PROCEDURE FOR FILING A CLAIM

1. Please attach all medical bills and receipts relating to the claim(s). Missing or incomplete claim information could delay processing and reimbursement.
 - a. Make sure the bills identify the patient.
 - b. All bills should show the date of treatment, description of service and amount of charges.
 - c. Procedure Codes and Diagnosis codes must be included or claim form will be returned.
 - d. All statements should have your identification number listed.
 - e. Mail to: University of Utah Health Plans
 PO Box 45180
 Salt Lake City, UT 84145-0180
 - f. Or fax to 801-281-6121 ATTN: Member Reimbursement
 - g. Or email to uuhp@hsc.utah.edu
2. For additional information please call 801-587-6480

Mileage Tracking (For use with personal vehicle only)

Origin Location (include Zip Code)	Destination (Include Zip Code)	Trip Description	Date	Miles	Code
					A0090
					A0090
					A0090
					A0090
					A0090
					A0090
					A0090
					A0090
					A0090
					A0090
					A0090
				Total Miles	0.00
				x 54.5¢ per mile	\$0.00



Utah Travel Reimbursement Benefit Form (2 of 2)

Name: _____
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 Member ID: _____
 Referral Number: _____

Description	Date	Details	(notes)	Cost	Code
Mileage total from page 1					A0090
				\$	
Lodging/Meals (member)	Date				A0180
				\$	
				\$	
				\$	
Lodging/Meals (escort)	Date				A0200
				\$	
				\$	
				\$	
Airfare	Date	From	To		A0140
				\$	
				\$	
				\$	
Car Rental or Bus	Date	From	To		A0110
				\$	
				\$	
				\$	
Gas (Rental only)	Date	From	To		A0170
				\$	
				\$	
				\$	
Taxi/ Shuttle	Date	From	To		A0100
				\$	
				\$	
				\$	
Parking/tolls	Date				A0170
				\$	
				\$	
				\$	
TOTAL REIMBURSEMENT				\$	-

