Travel Claim Expense Submission Form

Your benefit plan will reimburse travel expenses incurred for covered travel benefits as outlined in your health benefit plan documents. Please review your specific coverage when submitting your reimbursement request.

How do I get reimbursed for my travel expenses?

You must submit:

- Original receipts for lodging and transportation costs
- Travel Claim Expense Summary Form
- For mileage, the origination and destination addresses must be provided
- If a claim for the covered medical service that resulted in the travel expense will not be submitted for insurance payment, you must include proof that the medical service was performed and self-paid.
- Name of travel companion(s)
- Signed attestation

Claims may be submitted by mail or via My NCAS Account. To submit claims via the US Mail, mail the forms, receipts and attestation to:

Carefirst Administrators
P.O. Box 981608
El Paso, TX 79998

The Team Approach to Benefit Administration

All Fields are REQUIRED

1. MEMBER ID#	**2. GROUP NUMBER**	**3. PATIENT'S NAME (FIRST, MIDDLE INITIAL, LAST)**
4. PATIENT'S DATE OF BIRTH (MO/DAY/YEAR)	**5. PATIENT'S SEX** FEMALE MALE	**6. PATIENT'S RELATIONSHIP TO SUBSCRIBER:** SELF SPOUSE CHILD OTHER EXPLAIN:
7. SUBSCRIBER'S NAME (FIRST, MIDDLE INITIAL, LAST)		**8. DAYTIME TELEPHONE NUMBER (INCLUDE AREA CODE)** ( ) —
9. SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE)		

10. IS PATIENT COVERED UNDER OTHER HEALTH INSURANCE? _____NO _____YES

IF YES, NAME OF OTHER INSURANCE COMPANY _____

NAME OF POLICYHOLDER _____ POLICY OR IDENTIFICATION NUMBER _____

IF THE SUBSCRIBER IS MARRIED, IS THE SPOUSE EMPLOYED? _____NO _____YES

IF YES, GIVE THE NAME OF THE SPOUSE'S EMPLOYER _____

- **IS PATIENT COVERED UNDER MEDICARE? _____NO _____YES**
- **IF YES, PART A ☐ PART B ☐ MEDICARE NUMBER _____**
- **IS PATIENT ACTIVELY EMPLOYED? _____NO ____YES IF YES, NAME OF EMPLOYER _____**

11. Date of Service Associated with Travel Benefit
12. Covered Service Performed
13. Name of Provider of Covered Service/Address

Member ID: _____ Patient Name: _____

Travel Companion Information

Number of Travel Companions: ☐ Name(s): _____

Travel Cost: You must include receipts to be eligible for reimbursement.

Date of Service	Expense Type (Airfare, Parking, Tolls, etc.)	Provider (Ex: United, Uber, parking, toll)	Amount

Lodging: You must include receipts to be eligible for reimbursement. The maximum reimbursement for lodging is $50 per night/per person subject to other limitations described in your benefit contract.

Date(s) of Stay	Provider (Holiday Inn, Airbnb, Vrbo)	City/State	Amount

Mileage Reimbursement

Originating Address	Destination Address	Purpose	# of Miles

Member ID: _____ Patient Name: _____

Attestation for Travel Benefit Claim

Please initial each item below and attach this document to your claim form.

_____ I agree that there was no provider or facility that could provide the treatment for the Covered Service(s)* within 50 miles of the patient's home (or other number of miles as specified in accordance with the terms of the subscriber's Summary Plan Description (or Agreement).

_____ I agree that provider or facility that provided the treatment for the Covered Service(s)* is the ***nearest*** in-network provider (where available) or ***nearest*** out-of-network provider, if out-of-network provider benefits are available under the subscriber's Summary Plan Description, to the patient's home.

_____ I agree that the travel expenses listed above were incurred by the patient in order to receive treatment for a Covered Service* under the subscriber's Summary Plan Description.

I request benefits for the expenses listed on the claim form and certify that the above information is correct, including the attestation statements above, and that the foregoing expenses were incurred for the above-named patient. I authorize any physician, nurse, hospital or other providers or suppliers in possession of information concerning the patient to furnish such information to CareFirst upon request.

_____ _____

Member Signature Date

CAUTION: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may be subject to fines and confinement in prison.

** Covered Service means medically necessary services or supplies provided in accordance with the terms of the subscriber's Summary Plan Description (or Agreement).*