OhioHealthy
PO Box 2582
Hudson, Ohio 44236-2582

# Travel and Lodging Benefit Reimbursement Predetermination and Claim Form Instructions

Certain travel expenses, as outlined in the Plan Document and Summary Plan Description, are eligible for reimbursement, subject to any applicable deductible and coinsurance. A Travel and Lodging Benefit Reimbursement Predetermination and Claim Form must be completed for reimbursement consideration.

**Predeterminations:** If an Associate would like to confirm eligibility for expense reimbursement prior to traveling, the form can be submitted detailing the anticipated costs.

**Travel Claims**: Claims for travel reimbursement must include all receipts and proof of payments.

## Important Information:

**Incomplete forms will not be considered for reimbursement.**

**Please submit the Travel and Lodging Benefit Reimbursement Predetermination and Claim Form as follows:**

Fax: **330-656-1194**

Email: **OhioHealthy-NetworkExceptions@MemberAdvocate.com**

Web Portal: **https://www.ohiohealthyplans.com/**

Or mail to: OhioHealthy
Attn: OhioHealthy Travel Reimbursement
PO Box 2582
Hudson, Ohio 44236-2582

**If the service requires pre-authorization for medical necessity, a separate review is required. Preauthorization may be initiated by faxing an Authorization Request for Services form, along with supporting documentation to 800-385-7085 or 330-656-2449.**

By submitting this form, the submitter attests that s/he has the member's permission to submit on his/her behalf and that the information contained herein is the minimum necessary to request the services being requested.

All claims are subject to the eligibility guidelines, benefits, exclusions, and limitations outlined in the Plan as of the date services are incurred.

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# Travel and Lodging Benefit Reimbursement Predetermination and Claim Form

☐ Predetermination Request (prior to travel) – complete section 1 and 2
☐ Reimbursement Request (treatment complete) – complete section 1 and 3

## Section 1 – Predetermination Request & Reimbursement Request

| | | |
|---|---|---|
| **Member (Patient) Name** | | OhioHealthy Member ID: |
| **Member (Patient) Address** | | |
| | | |
| **Member (Patient) Phone #** | | |
| **Treatment Date Span** | | |

## Section 2 – Provider and/or facility information and reason for treatment

| | |
|---|---|
| **Name of treating provider** | |
| **Specialty of treating provider** | |
| **Address of treating provider** | |
| | |
| **Name of treating facility** | |
| **Address of treating facility** | |
| | |
| **Specialty of treating facility** | |

**Brief description of the service or diagnosis that is not treatable by an in-network provider or facility within 60 miles of your documented address:**

## Section 3 – Reimbursement Request & Receipts/Documentation (attach additional pages if needed)

| | | |
|---|---|---|
| **Miles Driven*** (Round Trip = miles driven from residence to treatment provider and back to residence, includes mileage from hotel to treatment provider and back to hotel) ***OR*** **Alternative Transportation*** (Bus, Train, Taxi, eTaxis - Uber, Lyft, etc.) | Date: | Miles OR Alternative Transportation Fare: |
| | | |
| | | |
| | | |
| | | |
| | | |
| | Total Miles Driven or Total Alternative Transportation Fares: | |
| **Lodging**** (Includes Hotel or online accommodation marketplaces – Airbnb, Vrbo, etc.) | • Number of nights: | |
| | • Cost Per Night: | |
| | • Total Hotel Charges (including fees and taxes): | |
| **Air Travel*** | Travel Dates: | Total Airfare & fees: |
| **Total Travel Reimbursement Requested:** | | |

*Reimbursement is paid up to the IRS guidelines
**Limited reimbursement of up to $200 per night, which may exceed IRS guidelines. If so, this may result in imputed income being reported on your Form W2.

*Any person who knowingly and with intent to injure, defraud or deceive 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 subjects such person to criminal and civil penalties. I certify that the information submitted is true and accurate to the best of my knowledge:*

Signature: _____ Date: _____