Claim for Reimbursement of Travel Expenses

Chevron Medical PPO, High Deductible Health Plan and High Deductible Health Plan Basic

Important – Please read before filing

The related qualifying *medical* claim for the covered service *must* be on file with and approved by Anthem *before* this claim for reimbursement of transportation and/or lodging expenses will be processed. As a reminder, if the medical service was received from a network provider, the provider will file a medical claim for you. If the service was received from an out-of-network provider, it is your responsibility to file a medical claim with Anthem. You can learn how to file a medical claim or check the status of all claims:

- From your Anthem website account at **www.anthem.com/ca**
- From the Anthem **Sydney Health** mobile app
- By calling Anthem at **1-844-627-1632**

Documentation Required

This travel benefit claim will be denied if all required information is not present.

- Member must include the related qualifying medical claim information on this reimbursement request:
  - Date the covered medical service was received. (*Qualifying claim date of service* field)
  - Claim number associated with the covered medical service, not required, but encouraged. (*Qualifying claim number* field)
  - Alternatively, attach a copy of the Explanation of Benefits for the related medical claim.
- A valid receipt must be submitted for each expense.
  - All receipts must be itemized and legible.
  - Itemization includes, but is not limited to: name, date, time, amounts, and purpose.
  - Credit card statements are not acceptable as documentation.
  - Remember to keep a copy of your claim form and itemized bills with your records.

Submission Instructions

- Submit your travel benefit claim as soon as possible after your related medical claim is approved. At the latest, you must file a claim for reimbursement of travel expenses no later than six months (by June 30) following the calendar year in which the covered service was provided. If you don't file a proper claim within this time frame, travel expenses for the related covered service will be denied. Refer to the summary plan description for more about claim filing limitations and exclusions.
- Remit copies of your itemized receipts, this completed travel benefit claim form, and any supporting documentation via **email** to: **Anthem_MTL_Member_Submit_Claim_Mailbox@anthem.com**. Submission via any other method will delay processing. Contact Anthem if you need help or have questions.
- The Member is responsible for the payment of services rendered.
- Submit a separate claim form for the patient and each eligible caregiver (if any)**.**
- All blocks and fields *must* be completed.
- Use a separate line for each date of expense and receipt.
- Briefly indicate the type of service, i.e., travel, etc. For travel by car list number of miles from permanent residence to treating facility.

Your signature on this claim form attests to the accuracy and completeness of all information on form, including the receipts, and that you acknowledge that any material omission or misrepresentation of facts may result in the denial of benefits, termination of coverage for you and your dependents and/or disciplinary action including and up to termination of employment. It also authorizes the release of your medical records by the provider to Anthem if necessary.

ONE PATIENT/CAREGIVER PER CLAIM FORM

IDENTIFICATION NUMBER:	GROUP NUMBER:	PATIENT NAME (LAST, FIRST, INITIAL)(*PLEASE PRINT*)	PATIENT BIRTHDATE: MO DAY YR

PATIENT RELATIONSHIP TO SUBSCRIBER: ☐ Self ☐ Spouse ☐ Child ☐ Other	SUBSCRIBER NAME:

IF WE HAVE QUESTIONS, WHO MAY WE CONTACT?

Name: _____ Address: _____ Phone: _____

☐ I attest that the covered service was not reasonably available from a network provider or facility within 100 miles of my home residence.	Qualifying claim date of service:	
	Qualifying claim number (not required):	

PLEASE COMPLETE THE FOLLOWING AS A SUMMARY OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM

DATE OF SERVICE	TYPE OF SERVICE (SEE LEGEND BELOW)	CHARGE FOR SERVICE (OR MILES TRAVELED)	BRIEFLY DESCRIBE THE SERVICES YOU RECEIVED OR INCURRED (IF EXPENSE INCURRED BY CAREGIVER(S), NOTE HERE)

TOTAL CHARGES FOR WHICH YOU ARE REQUESTING CONSIDERATION OF PAYMENT $_____	**TYPE OF SERVICE:** **T** – NUMBER OF MILES TRAVELED BY CAR **A** – AIRFARE (OVER 100 MILES FROM RESIDENCE) **L** – LODGING

I CERTIFY TO THE ACCURACY AND COMPLETENESS OF ALL INFORMATION REPORTED BY ME ON THIS FORM AND AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

_____

SIGNATURE **DATE**

FULL SIGNATURE AND DATE
REQUIRED ON EACH FORM
INCOMPLETE FORMS MAY DELAY PROCESSING. PLEASE ENSURE ALL FIELDS ARE ANSWERED.