PROVIDENCE Health Plan

MEDICAL TRAVEL REIMBURSEMENT FORM

If you are unable to locate an in-network provider within 50 miles of your home, you may be eligible for reimbursement of certain expenses incurred for travel to the nearest in-network provider within 300 miles from your home.

Prior Authorization is required; please contact Customer Service by calling the phone number listed on the back of your member ID card. Not all plans include coverage for Medical Travel Reimbursement. Please refer to your member handbook, contract, or summary plan description.

Please note:

- Not all expenses are eligible for reimbursement. Examples of some services not eligible for reimbursement include bus, plane, or train tickets; personal items, toiletries, alcoholic beverages, magazines, etc.
- Receipts are required for all reimbursement, with the exception of mileage.
- Mileage reimbursement is limited to a maximum of 300 miles each way and is reimbursed at the IRS medical transportation reimbursement rate of $0.19 per mile driven in 2016, and $0.17 per mile driven in 2017 **(https://www.irs.gov/pub/irs-drop/n-16-79.pdf)**
- Parking fees are not covered unless part of hotel charges.
- Food receipts must be itemized with items for the member circled.
- Lodging receipts must be itemized on hotel/lodging facility receipt or contract.
- Reimbursement is limited to a maximum of $1,500 per calendar year.
- Daily expenses for food and lodging are limited to $150 per day only when an overnight stay is required.

Please keep a copy of all items submitted.

Please complete the following, attach appropriate receipts, and mail to:

Providence Health Plans
ATTN: Claims
P.O. BOX 3125
Portland, OR 97208-3125

Member ID#: _____

Date(s) of Service(s): _____

Provider(s) of Service(s): _____

Total Reimbursement requested for mileage: **$** _____

Address of Starting Point: _____

Address of Destination: _____

Roundtrip Mileage for consideration: _____

[Approved mileage is reimbursed at a rate of $0.19 per mile for 2016; $0.17 per mile for 2017. Include fuel receipt(s)].

Total Reimbursement requested for food: **$** _____

[Include receipt(s). Benefit covers member only]

Total Reimbursement requested for lodging: **$** _____

Name of lodging facility: _____

Address of lodging facility: _____

Phone number of lodging facility: _____

Room number: _____

[Include receipt or contract along with number of guests. Benefit covers member only. Some items are not eligible for reimbursement including but not limited to, refundable deposits, furnishing rental/purchases, and phone charges.

Send reimbursement check to**:**

Name: _____

Address: _____

City, State, Zip: _____

Signature: _____ Date: _____

For PHP Use Only:
Total Approved Reimbursement: **$** _____ Date Issued: _____

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오.

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡くださいゐ!

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می‌کنید، تسهیلات زبانی بصورت رایگان برای شما میباشد. با تماس 1-800-878-4445 (TTY: 711) بگیرید.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)