Member Travel Benefit Form Requirements

(This form should not be used for travel related to transplant services.)

This form is only applicable to benefit plans that have implemented a travel benefit. Not all plans offer this benefit. Consult your plan benefit booklet or your Plan Administrator for information on whether your plan offers this benefit.

Please note the below filing requirements and tips for filling out the attached Member Travel Benefit Form. This form is only for covered and authorized (if required) travel expenses. Do not file medical services, prescription drugs or dental claims with this form.

Complete a Member Travel Benefit Form if you travel out-of-state for a covered and authorized (if required) medical service (under your plan) and ALL the below criteria are met:

- The medical service is not available in the state in which you reside, and
- There is no provider available within 100 miles of where you reside, and
- The medical service is not available via telehealth

Certain employer plans may have different conditions or requirements. Check your plan documents, or consult with your Plan Administrator.

Visit ***BlueCrossNC.com/Claims*** for medical, prescription drug, dental and international claims forms, or call the toll-free number on your ID card*.

Important Notes When Completing the Member Travel Benefit Form:

- Type or use blue or black ink to complete.
- Complete a separate claim form for each covered family member.
- Complete a separate claim form for each travel event.
- Claims must be filed within 18 months from the date services were received or they will be denied.
- If your address has recently changed, please contact Customer Service using the phone number located on the back of your ID card to ensure our records are accurate.
- Keep a copy of this form.
- Remember to sign and date in SECTION 4.

NOTE: Blue Cross and Blue Shield of North Carolina (Blue Cross NC) cannot process this travel benefit until the medical service claim is filed by your provider (or by you, for member submitted claims). This travel benefit will be denied if the corresponding medical claim has not been received and processed by Blue Cross NC or if the corresponding medical claim is for a non-covered service. Upon request, after the medical claim is processed, Blue Cross NC will reconsider a previously denied travel benefit claim.

*ID cards are for identification purposes only. They do not guarantee eligibility or payment of your claim.

Member Travel Benefit Form

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SECTION 1: Patient Information Please enter the subscriber number from your ID card

Subscriber Number: **Begin with letter prefix** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐–☐☐ **2 digits following member's name** (see ID card)

Patient's Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Daytime Phone Number: _____

Date of Birth: ☐☐–☐☐–☐☐☐☐

Relationship to Subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other: _____

Service(s) Provided for Which Travel Was Required: *(Example: Pregnancy related service, etc.)*

_____

Name of Provider or Facility: _____ **Date(s) of Service(s) Provided:** _____

Address of Provider or Facility: _____

City: _____ **State:** ☐☐ **ZIP Code:** ☐☐☐☐☐–☐☐☐☐

SECTION 2: Mailing Information

Subscriber Name: _____

Address: _____

City: _____ **State:** ☐☐ **ZIP Code:** ☐☐☐☐☐–☐☐☐☐

SECTION 3: Itemized Travel Costs — Payment Amount Will Vary Based on Your Plan*

			Amount:
a. How many nights were spent at a hotel (if applicable)? _____	Did you travel with a companion? ☐ Yes ☐ No	Rate: $50/night individual or $100/night companion	$ _____
b. What were the total miles driven (if applicable)? If a rental car was driven, skip this line and enter costs on line c. _____ mile(s)		Rate: $0.22/mile	$ _____
c. What was the total amount spent on any airfare, rental cars, trains, buses, taxis, rideshare services, parking fees or tolls (if applicable)? This may include companion transportation costs.			$ _____
		Total:	$ _____

*Consult your tax professional for information about potential tax implications of medical travel reimbursement.

Member Travel Benefit Form (continued)

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SECTION 4: Travel Benefit Attestation

I attest that the information provided on this form is correct and true and that ALL the travel benefit criteria required by my health plan have been met. (Members should refer to their Blue Cross NC plan documents for more information about what is covered.)

Member Signature: _____ **Date:** _____

SECTION 5: Submitted Form Information

MAIL THIS FORM TO:

Blue Cross and Blue Shield of North Carolina
P.O. Box 35
Durham, NC 27702
OR FAX TO: 1-866-990-1385