2024 Direct Member Reimbursement Request Form

For Medicare plan members

Medica®

Transplant Travel

A	HERE'S HOW TO COMPLETE THIS FORM

1. Fill out sections 1 and 2.
2. Please remember: To receive reimbursement for the travel expenses listed in section 2, you must attach copies of your itemized receipt(s) and proof of payment to this form.
3. Mail this completed form with attached receipt(s) to the address for your plan type. Plan types can be found on the front of your Medica ID card.

Note: Please submit one (1) request per reimbursement form. If you have more than one service to submit, please fill out separate forms for each request.

If you're enrolled in:	If you're enrolled in:
• **For Medica Advantage Solution® (HMO-POS, PPO)** • **Medica Advantage℠ (PPO)** • **Medica Group Advantage Solution℠ (PPO) Plans**	• **For Medica Prime Solution® (Cost)** • **Medica Group Prime Solution℠ w/Rx (Cost) Plans**
Mail form to:	**Mail form to:**
Medica Claims P.O. Box 21342 Eagan, MN 55121	Medica Claims P.O. Box 30990 Salt Lake City, UT 84130

Please allow 60 calendar days from the date Medica receives your form for your reimbursement check to be mailed to you. Reimbursement requests must be made within 365 days from the date of service. You will be reimbursed for covered expenses.

1	REIMBURSEMENT INFORMATION	
	Member information	
	Member name (as it appears on your Medica ID card):	
	Date of birth: ___ / ___ / _____	Phone number:
	Medica ID number:	Group number:
	Clinical visit information	
	Facility name:	
	Facility location (City, State, ZIP):	
	Date of service: ___ / ___ / _____	
	Hotel visit information	
	Hotel name:	Phone number:
	Number of hotel rooms:	
	Travel companion #1 (name):	
	Travel companion #2 (name):	

2	TRAVEL EXPENSE INFORMATION				
	Itemize your travel expenses (please print):				
	Travel date	**Auto mileage***	**Plane, train, taxi or bus expenses***	**incidental expenses (eg, tolls and parking)**	**Lodging****
	___ / ___ / _____	_____# of miles	$	$	$
	___ / ___ / _____	_____# of miles	$	$	$
	___ / ___ / _____	_____# of miles	$	$	$
	___ / ___ / _____	_____# of miles	$	$	$
		Total # miles_____	Total $	Total $	Total $

Have questions? We're here to help.

Call the Member Services number on the back of your Medica ID card. Visit **Medica.com/Forms** for additional copies of this form.

*Reimbursement for travel expenses includes miles traveled to and from your home to the approved hospital site. Mileage is reimbursed at the IRS medical mileage reimbursement rate. Medica will calculate the amount to be reimbursed.

**Lodging expenses are reimbursed based on your Medica plan.