HMA

Member Travel Reimbursement Claim Form

Instructions

Within this form, the terms "you" and "your" refer to the member. The terms "we", "our", and "us" refer to Regence Group Administrators (HMA), your third-party Health Plan administrator.

What's a travel benefit?
It's a benefit that pays you back for approved travel costs *after* you travel for an eligible medical procedure located outside of your state of residence. You may be eligible for reimbursement from your Health Plan for expenses you incurred from traveling.

Travel reimbursement is available only for in-network services covered under your Plan and for services which have already occurred. **Note:** Your Health Plan may or may not reimburse expenses for a companion traveler, such as your spouse or your caregiver.

1. **Before you travel for your procedure:**
   - Confirm your provider and the facility where the procedure is to occur are in-network. HMA Customer Care is available 800-869-7093 Monday - Friday between 5:00 AM – 6:00 PM Pacific Time if you have questions about this.
   - Find out what procedure you need/want and if it's covered by your Health Plan. If the service requires a prior authorization, get the pre-authorization confirmed by HMA in writing.
   - Find out if travel reimbursement is covered by your Health Plan, and if your type of travel meets the requirements of the benefit.
   - Find out if Travel Reimbursement requires pre authorization. If it does, get the pre-authorization confirmed by HMA in writing.
2. **Pay for your travel expenses.** You'll need to pay for these yourself up front. Save your receipts and travel documents. Travel-related expenses to/from your procedure may include, but aren't necessarily limited to the following. **Note:** Please check with your Health Plan, as not all of these are reimbursable or will be reimbursed in full.
   - Transportation expenses, such as airfare, rental car, public transportation, personal vehicle mileage, and parking.
   - Lodging expenses, such as hotel, motel, and Airbnb.
   - Meals
3. **Have your procedure:**
   - Meet with your provider, complete the applicable procedure, and return home when your provider says it's safe to do so.
4. **Request reimbursement for your travel expenses:**
   If your Health Plan covers travel reimbursement for the services you received, fill out and submit this form along with all documentation requested herein (such as receipts). We'll process your request for reimbursement within thirty calendar days.

Submission Information

Please include the following items with your submission. We won't be able to process your request without them.

- Copies of receipts for each expense for which you're requesting travel reimbursement. Each receipt must clearly show the expense description, date, and itemized amounts. Keep your original receipts.
- Your travel documents, such as plane ticket stubs showing the names and travel dates of you and, if applicable, your companion. Check with your Health Plan if companion travel is reimbursable.

Electronic Submission Options

✓ **Option 1: DocuSign**:
1. Go to https://www.accesshma.com/news-and-resources/member-forms
2. Click on the DocuSign option under **Member Travel Reimbursement Claim Form**
3. Fill out and submit the form in DocuSign

✓ **Option 2: HMA Member Portal**:
1. Go to https://www.accesshma.com/news-and-resources/member-forms
2. Click on the PDF option under **Member Travel Reimbursement Claim Form**
3. Fill out the form in compatible PDF software like Adobe Reader or Acrobat
4. Login to the member portal at https://accesshma.com/for-members
5. On the member portal, click on **Manage Claims & Deductibles**, click **Submit a Claim**, select **Medical**, and follow the prompts

Paper Submission Options

✓ **Option 1: Fax** the completed form to: 866-458-5488

✓ **Option 2: Mail** the completed form to:
HMA
Attn: Claims Department
PO Box 85008
Bellevue, WA 98015-2730

Any questions? We're here to help! Contact Customer Care 800-869-7093 Monday - Friday between 5:00 AM – 6:00 PM Pacific Time.

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Member Travel Reimbursement Claim Form

Patient Information

First Name ______________________ **Last Name** ______________________

Mailing Address ______________________

City ______________ **State** ______________ **ZIP Code** ______________

Phone Number ______________ **Member ID Number** ______________ **Date of Birth** ______________

Group/Employer Name ______________________ **Group Number** ______________

Patient's Relationship to Policyholder ○ Self ○ Spouse ○ Dependent

Which Medical Travel Benefit are you requesting reimbursement under? ○ Steerage ○ Transplant ○ Other Medical Travel benefit

Companion Information

First Name ______________________ **Last Name** ______________________

Relationship to Patient ______________________

Transplant Information – please complete only if you are applying for reimbursement under the Transplant benefit

Is travel for medical services related to a transplant? [ ] YES [ ] NO

(If no, proceed to Claim Information)

Are you requesting reimbursement for yourself, an identified donor or a potential donor? [ ] SELF [ ] DONOR[ ] POTENTIAL DONOR

(Note: A donor may or may not be covered under the provisions of this Plan. Potential donors may not be covered by all Plans. Consult your individual Summary Plan Description language.

Does your donor or potential donor have benefits available through other group coverage? [ ] YES [ ] NO

(Benefits for a donor are payable only in the absence of other coverage and shall not exceed the benefit limitation as shown in the Schedule of Benefits.)

Claim Information

Please provide information for the services that necessitated you travel outside of your state of residence. All of this information can be found on your Explanation of Benefits (EOB).

Provider Name ______________________ **Date(s) of Service** ______________

Claim Number(s) ______________________

General Travel Reimbursement Information

Please list all the travel-related expenses (except for mileage) for which you're requesting reimbursement. If you need to list more expenses than this space allows, please fill out the additional sheet at the end of this form. For mileage reimbursement, please go to the Mileage Reimbursement Information section.

Expense Date	$ Amount	For Whom?	Expense Type	If "Other", Describe the Expense

1 If your mailing address has changed, please notify your Human Resources (HR) department so they can update the eligibility information they provide to us.

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Expense Date	$ Amount	For Whom?	Expense Type	If "Other", Describe the Expense

Mileage Reimbursement Information

If you traveled by *personal vehicle* (in other words, *you drove yourself or your companion drove you*), your Health Plan *may* reimburse you for some or all of the miles you drove. Limits may apply. **Note:** Please *don't* count any miles you traveled using modes like public transportation, rental vehicles, or ride-sharing services like Uber or Lyft; please track those in the General Travel Reimbursement Information section.

Total Miles Traveled by Personal Vehicle (Round Trip): ________________

Attachments

Please be sure to include all relevant material with your submission. Otherwise, your claim might be delayed or denied. Relevant attachments include:

- The Explanation of Benefits (EOB) showing the services for which you're claiming travel reimbursement were covered by your Health Plan.
- Copies of receipts for each expense for which you're requesting travel reimbursement. Each receipt must clearly show the expense description, date, and itemized amounts. Keep your original receipts.
- Your travel documents, such as plane ticket stubs showing the names and travel dates of you and, if applicable, your companion.

Electronic or Paper Check Reimbursement Preference

Actions needed to receive my reinstatement electronically (Venmo, Direct Deposit, Zelle, etc.) in about two weeks.

1. Log into the RGA portal at www.accesshma.com
2. Click on the human icon to access your account preferences on the upper right corner of the screen
3. Choose Communication Preferences
4. Change Explanation of Benefits (EOB) from Paper to Email
5. Click Save
6. An email will be sent to you from SelectPay. In this email you will need to follow the link to the SelectPay website which will enable you to choose the type of electronic payment you prefer (Direct to Debit Card, Direct deposit (ACH), Zelle or Echeck), otherwise a paper check will be mailed to the address we have on file.

Note: **If you do not complete the above steps, you can expect a paper check mailed to the address we have on file in about three weeks.**

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Signature

Note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

By signing below, I indicate the following:

- I certify that the information I provided on this form is true and complete to the best of my knowledge.
- I certify that I had to travel out of state to receive these services because they weren’t available or appropriate in my state of residence.
- I certify that all expenses I’m claiming are for me and, if applicable, an authorized companion, such as a spouse or caregiver.

______________________________	______________________________
Printed Name (First and Last)	**Relationship to Patient (If you are the patient, put “Self”)**
______________________________	______________________________
Signature	**Date**

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General Travel Reimbursement Information (continued)

Please fill out this information only if the number of expenses you need to list exceeds the available space above.

Expense Date	$ Amount	For Whom?	Expense Type	If “Other”, Describe the Expense

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