

Instructions

Within this form, the terms “you” and “your” refer to the member. The terms “we”, “our”, and “us” refer to Regence Group Administrators (RGA of Idaho), 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. RGA of Idaho Customer Care is available at 1-833-670-0899 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 RGA of Idaho 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 RGA of Idaho 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**✓ RGA of Idaho Member Portal:**

1. Go to <https://www.accessrga.com> and select the applicable state
2. Click **Member** and then go to **Download Member Forms**
3. Click on the PDF option under **Member Travel Reimbursement Claim Form**
4. Fill out the form in compatible PDF software like Adobe Reader or Acrobat
5. Login to the member portal at <https://www.accessrga.com>
6. 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:

RGA of Idaho
Attn: Claims Department
PO Box 52730
Bellevue, WA 98015-2730

Any questions? We’re here to help! Contact Customer Care at 1-833-670-0899 Monday - Friday between 5:00 AM – 6:00 PM Pacific Time.



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.

Table with 5 columns: 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.



Member Travel Reimbursement Claim Form

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

