BlueCross BlueShield of Texas

REIMBURSEMENT FOR TRAVEL FORM

PO Box 660044 • Dallas, Texas 75266-0044

Each item on this form needs to be completed.
Please print or type (black ink only).

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Insured/Subscriber Name (Last, First, Middle Initial)	
Mailing Address	
City and State	**ZIP Code**

2

Group Number	**Insured/Subscriber Identification Number** (from ID card)
Patient's Full Name (Last, First, Middle)	
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other (explain) ________________	

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Is patient covered under any other health benefits plan? ☐ Yes ☐ No

Insurance Co. ______________________

Address ______________________

Employer ______________________

Insured Name ______________________

Policy # ______________________

	Month	Day	Year
Effective Date of Coverage	______ /	______ /	______
Date of Birth of Insured	______ /	______ /	______

Relationship to Patient ______________________

If the other coverage is primary, attach the other insurance company's Explanation of Benefits.

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I certify and acknowledge that:

- ☐ I am responsible for the accuracy of this form. The information I have stated in and submitted with this form is complete and accurate.
- ☐ The member named above is eligible for coverage of benefits under the plan.
- ☐ Reimbursement will be paid only in connection with covered services performed by an in-network provider or, if allowed by your plan, an out-of-network provider.
- ☐ The claim is for reimbursement of travel that was needed to access services that were not available from an in-network provider within the mileage requirements of the plan as well as any other terms and conditions of the plan.
- ☐ The member in fact received the services for which the travel was required.
- ☐ If any of the above statements are later determined to be not true, the member shall be required to return any benefit paid in connection with this claim.
- ☐ Reimbursement on this claim is subject to applicable law. Reimbursement is subject to the service, travel, and reimbursement being in accordance with all applicable laws or regulations.

Signature of Insured	**Date**	**Daytime Telephone Number**

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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Estimated Total Expense	Today's Date	Provider Name and Phone Number	Service Date and Description

Date	Travel			Lodging Facility (Name of Facility & Dollar Amount)
	Auto Mileage or Gas* (Number of Miles)	Plane, Train, Bus, Taxi, Tolls, Parking, etc. (Dollar Amount)	Companion(s) Name	
Totals		**$**		**$**

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SUBMIT THIS COMPLETED FORM WITH ITEMIZED BILLS AND RECEIPTS TO:
Blue Cross and Blue Shield of Texas
PO Box 660044
Dallas, Texas 75266-0044

You can also submit a claim online by sending a secure message through Blue Access for Members if Secure Messaging is available to your group:

SUBMITTING A CLAIM

- Log in to Blue Access for Member with username and password
- Click on 'Messages' on the top right-hand corner of the screen
- Select 'New Messages' on the left-hand side of Message Center and a new message will appear
- In the 'To' field drop down select Claims Submission Attachment
- In the 'Plan' field select the plan for which you're submitting a claim
- In the 'Subject' field type New Claim Submission
- In the 'Message' field put any other information you want to include about your claim
- Click 'Add Attachment' to attach this claim form and electronic copies of your receipts
- Click 'Send' once everything has been completed

For ALL Travel and Lodging QUESTIONS, call the Customer Service number on the back of your insurance ID card.

HOW TO SUBMIT YOUR CLAIM:

- Make copies of this form as needed. Keep one for an original copy.
- A copy of this form must be completed and included with each request for reimbursement.
- Credit card receipts are not acceptable in absence of original receipts.
- Do not highlight or circle covered items or cross off non-covered items on receipts.
- Cleaning supplies, personal items and/or miscellaneous items ARE NOT covered.
- Keep a copy of the entire claim for your records.
- For a faster return on your claim, please include a printout of your appointments from the facility.

REMEMBER TO OBTAIN RECEIPTS. PAYMENT CANNOT BE PROCESSED WITHOUT ORIGINAL RECEIPTS. COMPLETION OF THIS FORM DOES NOT GUARANTEE PAYMENT. (Please allow 6-8 weeks for your reimbursement.)

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Total amount for ALL covered services and supplies received.	**$**
Itemized bill(s) for covered expenses must be attached.	

* Ground transportation mileage will be reimbursed at the medical reimbursement rate (rates can be found at www.irs.gov).

BlueCross BlueShield of Texas

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD:	855-661-6965
35th Floor	Fax:	855-661-6960
Chicago, Illinois 60601	Email:	CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Complaint Portal:	https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Washington, DC 20201	Complaint Forms:	http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Texas

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。 洽詢一位翻譯員, 請撥電話 號碼 855-710-6984.
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したり することができます。料金はかかりません。通訳とお話される場合、855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
ພາສາລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກໍາລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄໍາຖາມ, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີ 855-710-6984.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił hodoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی،با شمار 855-710-6984 تماس حاصل نمایید.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị đang giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 855-710-6984.