PERS Gold and Platinum Travel Reimbursement Form

Submit completed forms directly to Blue Shield of California for reimbursement of **eligible travel expenses under your health plan.** Blue Shield will cover travel and lodging for eligible medically necessary services including, but not limited to, the services listed below that cannot be accessed within 50 miles from the member's permanent residence up to $5,000 per occurrence. This includes transportation, lodging, and meals for the member and a companion (both parents/guardians when patient is under 18). Please note, duplicate claims will not only be rejected but may delay payment of the original claim. Please include a clear, readable copy of all relevant receipts. If you have questions, please call Included Health at (855) 633-4436.

Submit completed form and receipts to:
Blue Shield of California, P.O. Box 272530, Chico, CA 95927-2530
Or fax (248) 733-6331

Please select the type of travel reimbursement. Coverage is identified as a reimbursable expense under your health plan:

- ☐ Bariatric
- ☐ Gender-affirming care
- ☐ Pregnancy termination (requires a claim on file for services or documentation showing proof that services were rendered) ☐ Documentation of services included
- ☐ Transplant
- ☐ Acute inpatient pediatric care (except direct admission to the neonatal intensive care unit)
- ☐ Specialty inpatient pediatric care (except direct admission to the pediatric intensive care unit)
- ☐ Outpatient pediatric hematology and oncology, including preoperative and postoperative visits
- ☐ Other _____

Travel receipts should include:	**Travel exclusions:**
• Date(s) of service • Mileage • Taxi / ride share receipts • Airline receipts • Hotel receipts • Food receipts • Total charges • Identification of companion charges	• Tobacco, alcohol, drugs, phone charges, television, recreation, and personal expenses. • Premium economy, business, or first-class airfare. • Limousine and car services. Taxi and ride share is allowable. • Expenses reimbursed by another source (e.g., employer or non-profit).

Name, address of subscriber, and procedure details

Subscriber number:	Subscriber group number:	
Subscriber name:	Patient Social Security number:	
Subscriber's mailing address:		
City:	State and ZIP:	
Patient name:	Date of birth: (mm/dd/yyyy)	
Relationship to subscriber: (Self, child, spouse)		Gender:
Medical procedure:	Date of procedure:	
Performing physician:	Location of procedure:	

Reimbursement of travel costs (check all that apply. When applicable, must be a reimbursable expense under your health plan)

☐ Transportation for patient and companion if applicable (airfare, uber, etc).	Amount:
☐ Transportation personal mileage	Total miles round trip:
Location from:	Location to:
☐ Hotel accommodations	Amount:
☐ Meals for patient and companion, if applicable	Amount:
☐ Additional companion expense	Amount:
Travel reimbursement total:	

☐ By checking this box, I understand that any travel reimbursement expense may be tax reportable. The patient's Social Security number (SSN) is required for tax reporting purposes. Reimbursements that do not include the patient's SSN will not be processed.

By submitting this form, I am certifying that I had to travel to access these services; and that the travel expenses included on this claim form were necessary for my travel. I certify that the foregoing information is accurate and complete, and authorize the release of any medical information necessary to process this claim:

Signature of patient. A parent/guardian may sign on behalf of a minor patient. Date