Travel Benefit Reimbursement Form: Covered Services Restricted by State Law

Harvard Pilgrim Health Care and Tufts Health Plan are committed to providing members with access to covered services. Our travel benefit provides coverage for travel expenses that are primarily for and essential to obtaining covered services that are restricted or prohibited in your state of residence as a result of state law.

Complete this form and attestation to request reimbursement for these travel expenses. All required fields (*) must be completed to ensure timely review and processing.

Get started now

1 Confirm your plan has this travel benefit by referencing your updated plan documents on the member portal or by calling the Member Services number on your member ID card.

2 Confirm you meet the eligibility requirements below:

- Must not have access to the covered benefit in your state of residence due to a state law restriction.
- Travel must be primarily for and essential to receiving the covered benefit.
- You must travel at least 100** miles from your residence to receive services.

*****Some eligibility requirements and benefit limits may vary based on your health plan. Please refer to your plan documents for details related to your coverage.***

3 Submit the following to the address listed at the end of this form (any missing information may result in delay or denial of the reimbursement):

a. This completed and signed reimbursement form, including attestation of eligibility.
b. Proof of payment for travel.

Reimbursement will be sent to the member at the address the Plan has on record. To view your address of record, please log on to your secure member account at **harvardpilgrim.org** or **mytuftshealthplan.com** as applicable, or call Member Services at the number listed on your member ID card.

NOTE: Members may be entitled to reimbursements for eligible travel expenses such as:

- **Coach class airfare transportation**
- **Lodging at $50** per day or $100** per day if traveling with a necessary companion**
- **Meals are excluded per IRS guidelines**

**Required fields*

TUFTS Health Plan

Harvard Pilgrim Health Care

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Member information

Member listed below is receiving covered medical services that are restricted or prohibited in the member's state of residence as a result of state law, and the travel expenses are essential to and primarily for receiving these services. By providing your contact information below, you agree to be contacted by us via email and/or phone regarding your plan benefits and administration. ***Please provide all required information (as noted by the asterisk*).***

Please Note: *Reimbursement will still be sent to the address the plan has on record for the member unless otherwise noted. To update the address for receipt of this reimbursement please call the Member Services telephone number on your ID card.*

*Subscriber Last Name	*First Name	*Middle Initial
*Member Last Name	*Member First Name	*Member Middle Initial

*Street address

*Town/City	*State	*ZIP code

*Member health plan ID #	*Date of birth (MM/DD/YYYY)

Email address	Mobile phone number	Home phone number

Service information

Please complete the information below:

Place of Service (Check one):	Provider Name:	Date(s) of service (MM/DD/YYYY):
☐ Providers Office		
☐ Clinic		
☐ Hospital/Facility		

**Required fields*

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Travel information

Lodging is reimbursed when medical care is provided by a physician in a licensed hospital or in a medical care facility which is related to, or the equivalent of, a licensed hospital. The below claim and travel information must be related to the Member listed above. ***Please complete all applicable fields related to travel expenses.***		Section is for internal use only:
Dates of Travel (MM/DD/YYYY- MM/DD/YYYY)		
Total Miles Driven Round Trip[1]		
Cost of Airfare for Member		
Cost of Airfare for Companion,[2] if applicable		
Cost of all other covered transportation		
Number Nights Lodging[3]		
Total Cost of Lodging[3]		
All other travel costs (i.e., tolls, parking)		

[1] Mileage will be reimbursed at IRS guideline level, currently set at .22 cents per mile and includes gasoline.
[2] Companion travel will be reimbursed if a companion is necessary to enable the member to receive care (e.g., minor requiring parental consent and/or member requires sedation for services). Companions are limited to 1 under this benefit.
[3] Lodging will be reimbursed at a maximum of $50** per night or $100** per night if a companion is necessary.

No reimbursement is available for costs already reimbursed through a flexible spending account (FSA) or health reimbursement account (HRA). Expenses for which you are reimbursed under a health plan may be ineligible for tax-free reimbursement under a Health Savings Account (HSA). Questions concerning HSA taxation should be referred by you to a personal tax advisor at your own expense.

Member signature (required)

I attest that the above information is true and accurate and that the travel expenses submitted for reimbursement were paid by me in the amount requested as indicated above. I further attest that my employer offers this travel benefit, these travel expenses are primarily for and essential to receiving covered medical services that are restricted or prohibited in my state of residence as a result of state law, and that I had to travel at least 100** miles to obtain these covered services. I further acknowledge that failure to meet these eligibility requirements may result in this reimbursement being considered taxable income, and that I should consult my tax advisor.

I acknowledge that there may be consequences for submitting any false or misleading information as described in my Explanation of Coverage or Member Handbook. I understand that reimbursement payment will be made to the member listed above and will contain information about the service (e.g., termination of pregnancy, gender affirming surgery for minors). I also understand that Harvard Pilgrim Health Care or Tufts Health Plan, as applicable, may request any additional information it deems necessary to verify that the travel expenses were received for the covered purpose and payment was made.

*Signature (Subscriber signature if Member is a minor)	*Date (MM/DD/YYYY)

**Required fields*

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Let's double check

- ☐ I have completed and signed this form in its entirety.
- ☐ I have enclosed proof of payment and copies of all receipts for applicable covered services.
- ☐ I understand that most completed reimbursement requests are processed within 30 days.

Mail this form and proof of payment to the appropriate company below based on your member ID card:

Harvard Pilgrim Health Care
P.O. Box 699183
Quincy, MA 02269

Tufts Health Plan
Member Reimbursement Claims
P.O. Box 9191
Watertown, MA 02471-9191

**Required fields*