blue california
Promise Health Plan

Related Travel Expenses for Transportation Reimbursement Request Form

Use this form to request reimbursement for eligible Related Travel Expenses for Transportation. Please provide the information requested below. If you have any questions, please call the Customer Care number on your Blue Shield Promise ID card.

Member/Donor Information

First Name _____ Last Name _____
Subscriber ID (if Member) or Social Security Number (for non-member) _____
Date of Birth _____
Address _____
City _____ State _____ ZIP _____
Phone Number _____
Email Address _____

Attendant (Aide) Information (if applicable)

First Name _____ Last Name _____
Subscriber ID (if Member) or Social Security Number (for non-member) _____
Address _____
City _____ State _____ ZIP _____
Phone Number _____
Email Address _____

Service Information

Name and phone number of the doctor who performed the service: _____

Purpose of visit (choose all that apply):

☐ Consultation ☐ Treatment ☐ Surgery ☐ Follow-up ☐ Pre-op ☐ Post-op

Date(s) of service: _____

Did you have an attendant (aide)?

☐ yes ☐ no

Was attendant approved by your doctor? If you have a signed note from the ordering doctor, please provide a copy. ☐ yes ☐ no

Travel Duration: Start Date _____ End Date _____

Provide all receipts for every day reimbursement is being requested. Reimbursement will be provided up to the maximum daily IRS amount per person. If mileage reimbursement is approved, reimbursement is based on the IRS medical mileage rate.

Transportation (if applicable):

Mileage:

Total Due for Attendant _____

Parking:

Total Due for Member/Donor _____ Total Due for Attendant _____

Tolls:

Total Due for Member/Donor _____ Total Due for Attendant _____

Other: _____

Total Due for Member/Donor _____ Total Due for Attendant _____

Lodging (if applicable):

Total Due for Member/Donor _____ Total Due for Attendant _____

Meals (if applicable):

Total Due for Member/Donor _____ Total Due for Attendant _____

Other (if applicable): _____

Total Due for Member/Donor _____ Total Due for Attendant _____

Member/Donor Signature: _____

☐ Please check if you are a parent/guardian of a minor.

Member/Donor Print Name: _____ Date: _____

Submit this form and all receipts to:
Attn: Reimbursement Dept.
3840 Kilroy Airport Way
Long Beach, CA 90806

Fax: 323.889.5049
Attn: Reimbursement Dept.