Claim Form For Travel Reimbursements

This form is to be used for request of travel reimbursement in relation to travel expenses for organ transplant services.

- Benefits are provided for reimbursement if the facility is greater than 50 miles from the recipient's home.
- $150/ day limit for reasonable lodging and meals.
- Ground travel is reimbursed based on mileage from the recipient's home or temporary lodging to the transplant facility.
- Reimbursement is calculated using Peak Health current mileage reimbursement rate.
- Air travel is reimbursed at the price of the airline ticket (coach class).
- Tolls and Parking incurred while traveling between the recipient's home or temporary lodging and transplant facilities.
- There is a $10,000 aggregate limit for all travel costs.
- The reimbursement period begins 5 days prior to a transplant and ends 12 months after the date of transplant. Reimbursement applies to the recipient(adult) and one other person. If the recipient is a child, two adults are covered.

Peak Member Information		
Last Name:	First Name:	
Date of Birth:		
Home Address:		
City:	State:	Zip Code:

Claimant		
Last Name:	First Name:	
Date of Birth:		
Home Address:		
City:	State:	Zip Code:
☐Recipient ☐Donor ☐Traveling Companion		
Date of Birth:		
Peak Member ID (if applicable):		

Contact Information (this information will be used if Peak has questions about this claim)
Email address:
Phone Number:

Claim Summary		
Date of Transplant:		
Transplant Facility:		
Facility Address:		
Street Address:		
City:	State:	Zip Code:
Patient Name:		
Living Donor Name (if applicable):		
Type Of Receipts: ☐ Meals ☐ Lodging ☐ Mileage (Only used for Personal Car) ☐ Gas (Only used for rental cars) ☐ Parking /Tolls		

Name	**Date(s)**	**Type of Receipt**	**Cost**
Example: Hilton Gardens	*1/1/23-1/2/23*	*Lodging*	*$85.23*

Name	Date(s)	Type of Receipt	Cost
Total			$

*Attach Original Receipts: keep copies of all receipts and this form.

Declaration: I declare that to the best of my knowledge and belief the information I have provided in the Claim Section of this form is full, true, and complete.	
Name:	Date:

If you have questions about this form or the process for submission, please call Member Service at 1-833-569-7325.

Mail the completed form and attached receipts to:

Peak Health

1085 Van Voorhis Road, Suite 300

Morgantown WV 26505-3497

- ✓ Please allow 2 weeks processing time.
- ✓ Payment will be made to the address on file under Claimant.
- ✓ Payment will be made in the form of a paper check.