



Travel Reimbursements for Transplant Services Claim Form

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

- Benefits are provided for reimbursement if the facility is greater than 50 miles from the recipient's home (one way).
- \$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 are reimbursable.
- 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.
- Reimbursement is calculated using Peak Health current mileage reimbursement rate as defined by the IRS.

To receive reimbursement according to your benefits, please submit the following documentation within **6 months** from date of travel:

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

Transplant 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):
Best 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		

Original Receipts for each must be included with form submission

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

Mileage Claim Summary for Personal Vehicle only

Date	Starting Address	Destination Address	Odometer (Start)	Odometer (End)	Total Miles	Travel Purpose
EX: 4/4/2026	1 Medical Center Dr, Morgantown WV 26554	John Hopkins Transplant Center 601 N Caroline St, Baltimore, MD 21287	21345	21558	213	Pre Op Testing

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 45 days processing time.
- ✓ Payment will be made to the address on file under Claimant.
- ✓ Payment will be made in the form of a paper check.