OhioHealthy
P.O. Box 4278
Clinton, IA 5273-4278

Travel and Lodging Benefit Reimbursement Predetermination and Claim Form Instructions

Certain travel expenses, as outlined in the Plan Document and Summary Plan Description, are eligible for reimbursement, subject to any applicable deductible and coinsurance. A Travel and Lodging Benefit Reimbursement Predetermination and Claim Form must be completed for reimbursement consideration.

Predeterminations: If an Associate would like to confirm eligibility for expense reimbursement prior to traveling, the form can be submitted detailing the anticipated costs.

Travel Claims: Claims for travel reimbursement must include all receipts and proof of payments.

Important Information:

Incomplete forms will not be considered for reimbursement.

Please submit the Travel and Lodging Benefit Reimbursement Predetermination and Claim Form as follows:

Email: hb-ohyclaims@luminarehealth.com

Web Portal: https://www.ohiohealthyplans.com/

Or mail to: OhioHealthy
Attn: OhioHealthy Travel Reimbursement
P.O. Box 4278
Clinton, IA 5273-4278

If the service requires pre-authorization for medical necessity, a separate review is required. Preauthorization may be initiated by faxing an Authorization Request for Services form, along with supporting documentation to 717-295-1208

By submitting this form, the submitter attests that s/he has the member's permission to submit on his/her behalf and that the information contained herein is the minimum necessary to request the services being requested.

All claims are subject to the eligibility guidelines, benefits, exclusions, and limitations outlined in the Plan as of the date services are incurred.

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Travel and Lodging Benefit Reimbursement Predetermination and Claim Form

- ☐ Predetermination Request (prior to travel) – complete section 1 and 2
- ☐ Reimbursement Request (treatment complete) – complete section 1 and 3

Section 1 – Predetermination Request & Reimbursement Request

Member (Patient) Name		OhioHealthy Member ID:
Member (Patient) Address		
Member (Patient) Phone #		
Treatment Date Span		

Section 2 – Provider and/or facility information and reason for treatment

Name of treating provider	
Specialty of treating provider	
Address of treating provider	
Name of treating facility	
Address of treating facility	
Specialty of treating facility	
Brief description of the service or diagnosis:	

Section 3 – Reimbursement Request & Receipts/Documentation (attach additional pages if needed)

Miles Driven* (Round Trip = miles driven from residence to treatment provider and back to residence, includes mileage from hotel to treatment provider and back to hotel) ***OR*** **Alternative Transportation*** (Bus, Train, Taxi, eTaxis - Uber, Lyft, etc.)	Date:	Miles OR Alternative Transportation Fare:
	Total Miles Driven or Total Alternative Transportation Fares:	
Lodging* (Includes Hotel or online accommodation marketplaces – Airbnb, Vrbo, etc.)	• Number of nights:	
	• Cost Per Night:	
	• Total Hotel Charges (including fees and taxes):	
Air Travel*	Travel Dates:	Total Airfare & fees:
Total Travel Reimbursement Requested:		

*Member should consult their plan documents for benefit coverage and reimbursement guidelines.
Reimbursement for travel expenses related to a covered medical procedure that exceed the IRS guidelines may be considered tax able income. Consult a tax professional or IRS.gov for additional tax information.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I certify that the information submitted is true and accurate to the best of my knowledge:

Signature: _____ Date: _____