Medical Travel Reimbursement Form

Please complete this form for reimbursement for certain travel expenses related to obtaining medical services. To be eligible, your employer must opt into this benefit.

Employee Information (Policyholder)

Employee Full Name	Member ID # (located on front of Medical ID card)	Date of Birth

Address	City	State	Zip Code

Employer's Name	Employer Group ID # (located on front of Medical ID card)

Claim Information

Member's Full Name (Enter the name of the person the claim is for)	Member ID # (located on front of Medical ID card)	Date of Birth

This claim reimbursement is for (choose one)

☐ Employee (Policyholder) ☐ Spouse (of Policyholder) ☐ Dependent ☐ Ex-Spouse

☐ Other (Specify) _____

Travel Information

Did you travel with a companion?

Your companion's travel costs will also be reimbursed if the companion's presence is *necessary* for you to receive the medical services. Please include their costs in the totals below.

☐ Yes ☐ No Date of Covered Service _____

SAVE AND ATTACH ALL OF YOUR RECEIPTS, AND FILL OUT THE FOLLOWING AS APPLICABLE:

Dates of Travel* (MM/DD/YYYY)	Location of Service	Total Miles Driven (Round Trip)	Cost of Airfare	All Other Covered Transportation	Lodging	
/ / To / /	From To	Mi.	$	$	Average cost of lodging per night	$
					Number of Nights	
					Total Lodging Cost	$

***PLEASE NOTE**: Submission dates should not be prior to reproductive travel plan benefit effective date.

Authorization & Signature

Important Information & Reminders

- Confirm all receipts have been attached with form when submitting.
- Reimbursement may be considered taxable income, so you should consult your tax advisor.
- Certification and Authorization (This form must be signed and dated below.)
- Submit completed from and all required documentation to https://secure.ebpabenefits.com/ under the "Medical" option.

I certify that the information provided in support of this submission is complete and correct, and that I have not previously submitted for these purchases.

I understand that EBPA may require proof of payment for a reimbursement decision. I authorize the release of any information about purchases to EBPA.

Employee or Member Signature_____**Date**_____