BlueCross BlueShield Nebraska

TRANSPORTATION AND LODGING MEMBER CLAIM FORM

Complete this form for reimbursement from Blue Cross and Blue Shield of Nebraska (BCBSNE) for certain travel expenses related to covered services. To be eligible, your employer must opt into this benefit.
Submit one claim form per travel occurrence.

SUBSCRIBER INFORMATION

1. BCBSNE ID Number: ALPHA PREFIX | NUMBERS
2. Subscriber's Daytime Phone Number: AREA CODE | TELEPHONE NUMBER
3. Subscriber's Name: LAST NAME | FIRST NAME | M.I.
4. Subscriber's Address: Street: | City: | State: | ZIP:
5. Date of Birth: PLEASE ENTER AS — MMDDYYYY
6. Sex: ☐ Male ☐ Female

PATIENT INFORMATION

7. Patient's Name: LAST NAME | FIRST NAME | M.I.
8. Patient's Address: Street: | City: | State: | ZIP:
9. Date of Birth: PLEASE ENTER AS — MMDDYYYY
10. Sex: ☐ Male ☐ Female
11. Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

TRANSPORTATION AND LODGING INFORMATION

12. Purpose of travel: _____
13. Date of Procedure (MM/DD/YYYY): _____
14. 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 services. If yes, include how many companions accompanied you, and include their costs in the table below.
☐ No, I did not travel with a companion. ☐ Yes, I traveled with _____ companion(s).
15. PROVIDE YOUR RECEIPTS, AND FILL OUT THE FOLLOWING AS APPLICABLE:

DATES OF TRAVEL MM/DD/YYYY - MM/DD/YYYY	TOTAL MILES DRIVEN (ROUND TRIP) S0215	COST OF COVERED TRANSPORTATION T2002	LODGING S9976
			NUMBER OF NIGHTS:
			TOTAL LODGING COST:

Important Information

- Original receipts must be attached for reimbursement to be processed. Make a copy of your receipts for your own documentation purposes.
- BCBSNE will make a reimbursement decision within 30 calendar days of receiving a completed request form.
- Reimbursement is sent to the member's address on file with BCBSNE. Reimbursement may be considered taxable income, so you should consult your tax advisor.

Certification and Authorization (This form must be signed and dated below.)

I certify that the information provided in support of this submission is complete and correct, and that I am claiming benefits for charges incurred by the above-named patient, and that I have not previously submitted for these purchases. I understand that BCBSNE requires proof of payment for a reimbursement decision. I authorize the release of any information about purchases

Subscriber or Member's Signature: _____ Date: _____

SUBSCRIBER INFORMATION:

1. BCBS ID NUMBER: Enter the identification number and any alpha prefix as shown on your Blue Cross and Blue Shield ID Card. (If you are age 65 or older, this number may not be the same as your Medicare number).

2. SUBSCRIBER'S DAYTIME PHONE NUMBER: The area code and phone number of the subscriber. This can be a landline or cell number.

3. SUBSCRIBER'S NAME: Enter the subscriber's name as shown on subscriber's ID card.

4. SUBSCRIBER'S ADDRESS: Enter the home address of the subscriber.

5. SUBSCRIBER'S DATE OF BIRTH: Enter the date of birth of the subscriber providing the month as two digits (MM), day as two digits (DD) and year as four digits (YYYY).

6. SUBSCRIBER'S SEX: Check the appropriate box for the sex of the subscriber.

PATIENT INFORMATION:

7. PATIENT'S NAME: Enter the patient's FULL LEGAL NAME (not a nickname); please include "Sr." or "Jr." if applicable.

8. PATIENT'S ADDRESS: Enter the home address of the patient.

9. PATIENT'S DATE OF BIRTH: Enter the date of birth of the patient providing the month as two digits (MM), day as two digits (DD) and year as four digits (YYYY).

10. PATIENT'S SEX: Check the appropriate box for the sex of the patient.

11. PATIENT'S RELATIONSHIP TO SUBSCRIBER: Check the appropriate box to indicate the relationship of the patient to the subscriber.

TRANSPORTATION AND LODGING INFORMATION:

12. PURPOSE OF YOUR TRAVEL? Provide essential covered medical condition for this travel.

13. DATE OF COVERED SERVICE? Provide actual date of medical procedure.

14. DID YOU TRAVEL WITH A COMPANION(S)? Check the appropriate box to indicate if companion has traveled with you.

15. TRAVEL AND LODGING DETAILS
    - DATES OF TRAVEL? Provide beginning and end dates of travel.
    - TOTAL MILES DRIVEN? Provide total miles driven from the first date of travel to the last date of travel.
    - COST OF COVERED TRANSPORTATION? Provide total cost of transportation, does not include fuel (e.g., car rental, air flight, bus or any other form of transportation).
    - COST OF LODGING? Provide itemized statement of hotel charges.

MAIL THE REQUIRED INFORMATION TO:

Blue Cross Blue Shield of Nebraska
PO Box 3248
Omaha, NE 68180-0001

