Travel and Lodging Claim Form For Orthopedic Services

Anthem

Background

OrthoIndy has been named the preferred orthopedic provider for State of Indiana employees and their family. If the member chooses OrthoIndy, the Plan may provide assistance with reasonable and necessary travel expenses. The member must obtain prior approval and be required to travel more than 50 miles from their residence to reach the facility where the member will receive the inpatient or outpatient orthopedic surgical procedure.

The Plan's assistance with travel expenses includes ground transportation to and from the facility and lodging for the patient and one companion for an adult member, or two companions for a child patient. The member must submit itemized receipts for transportation and lodging expenses along with the Anthem Travel and Lodging Claim Form for Orthopedic Services. Anthem will follow the Internal Revenue Services (IRS) guidelines in determining what expenses can be paid.

How to file

The qualifying medical claim must be on file before Anthem will reimburse for Travel and Lodging. The member must include the claim date of service and/or claim number or attach a copy of their qualifying claim's Explanation of Benefits.

The member is responsible for the payment of services rendered and should validate covered expenses prior to submitting this claim form.

A valid receipt must be submitted for the expenses. All receipts must be itemized and legible. Itemization includes, but is not limited to, name, date, time, amounts, and purpose. Credit card and bank statements are not acceptable as documentation. Keep a duplicate copy of your itemized bills and receipts as they will not be returned to you.

It is required that all fields are completed. Use a separate line for each date of service and receipt. The number of occupants for lodging should be documented in the description section of the claim form. For consecutive nights of lodging on one receipt, it is acceptable to list on one line as a date range.

Briefly indicate the type of service, i.e., mileage, lodging, etc. For travel by car list the total number of miles traveled for treatment. Utilize type of service "Other" for each covered expense that is not specifically called out on the claim form. Expenses that are not covered should not be included.

Your signature attests to the accuracy and completeness of all information on the claim form (**including** the receipts). This claim may be returned to you if all required information is not present.

We encourage you to file claims within 90 days of the service date. Please refer to your Description of Benefits for specific timely filing limitations and any applicable limitations and exclusions.

Please remit photocopies of your itemized receipts, completed claim form and any supporting documentation to:

SOITravelandLodging@anthem.com

Please note: Submission of this form outside the above email address (via Member Portal, USPS mailbox address, etc.) may delay processing.

If you have questions or need assistance, please contact the number indicated on the back of your ID card.

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One patient per claim form.

General information

Identification no.	Group no.	Patient last name	First name	M.I.
Patient date of birth (MMDDYYYY)	Patient relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other	Subscriber last name	First name	M.I.

If we have questions, who may we contact?

Contact name	Address	Phone no.

	Qualifying claim date of service (MMDDYYYY)	Qualifying claim number

Please complete the following as a summary of the itemized bills you have attached to this claim form.

Date of service (MMDDYYYY)	Type of service code (T, A, L, or O) see below*	Charge for service (or miles traveled)	Briefly describe the services you received or incurred

Total charges for which you are requesting consideration of payment $_____

***Type of service code:**
T - number of miles traveled by car
A - airfare
L - lodging
O - other

I certify to the accuracy and completeness of all information reported by me on this form and authorize the release of any medical information necessary to process this claim.

Signature X	Date (MMDDYYYY)

Full signature and date required on each form.
Incomplete forms may delay processing. Please ensure all fields are completed.