SHARP HEALTH PLAN

CalPERS Member Reimbursement Request Form

Travel & Lodging

Purpose

The purpose of this form is to ask for a refund from Sharp Health Plan for the cost of travel and lodging for medically necessary services that are not available from our plan network within 50 miles from a member's residence. Medical services must be authorized before submitting your request for reimbursement unless otherwise noted.

Instructions

1. You must submit your reimbursement request within 180 days of the date of service. The maximum reimbursement is $5,000 per occurrence.
2. Travel and lodging expenses are covered for the following services when a Sharp Health Plan network provider is not available within 50 miles of your permanent residence:
   - Abortion
   - Bariatric surgery
   - Gender-affirming care
   - Organ and tissue transplants
   - Outpatient pediatric hematology and oncology
   - Acute or specialty inpatient pediatric care, except direct admission to the neonatal intensive care unit (NICU) or pediatric intensive care unit (PICU)

   An authorization or referral is required for all services except abortion. Services must be legal in the state in which they are rendered.
3. Covered expenses:
   - Travel to facility. Round-trip coach or economy airfare, bus or train tickets. Taxi or rideshare services, standard-class rental cars, parking and tolls are also covered.
   - When driving a personal car, mileage to and from the facility is covered. Mileage is reimbursed at the current IRS mileage rate.
   - Hotel room. Limited to one room, double occupancy, room rate and tax, up to $200 per night.
   - Meals for member and companion, up to maximum of $100 per person per day.
   - Coverage is limited to preservice visits, surgery/ treatment and follow-up visits.
4. Expenses for one travel companion are also covered (two companions may accompany a minor).
5. Complete a separate form for each member who is requesting reimbursement. Only one form is needed per member.
6. The member who received the medical services must sign this form. If the member is under 18 years old, the form must be signed by a parent or guardian.
7. The following are excluded from coverage: alcohol, tobacco, lodging other than a hotel or motel, tips, phone calls, entertainment and expenses for anyone other than the member and companion(s).
8. A Social Security number is required for reimbursement. Reimbursement may be considered taxable income. Please consult with your tax advisor.
9. Send this completed form and the following documents to Sharp Health Plan. Incomplete forms and missing information may result in a delay or non-payment of your request. Please keep copies of all documents for your records. Documents submitted to Sharp Health Plan will not be returned. You will need the following information to complete this form:
   - Travel receipts: airline, bus, train, taxi or rideshare, rental car receipts
   - Hotel invoice
   - Itemized meal receipts
   - Itemized invoices with proof of payment from hotels, airlines and rental car agencies, rather than credit card receipts
10. The reimbursement check will be sent to the member's address on file within 30 days of receiving complete documentation.

Submit

Please submit the finished form and required documents online, by mail or by fax:

Online:
Log in or create a Sharp Health Plan online account at **calpers.sharphealthplan.com/login**
Select **Claims**, then **Travel & lodging reimbursement form**

By mail:
Attention: Claims Research
Sharp Health Plan
8520 Tech Way, Suite 200
San Diego, CA 92123

By fax:
Attention: Claims Research
1-858-636-2276

Member Information (Complete This Section for All Reimbursement Requests. All Fields Are Required.)			
First name:	Last name:	M.I.	Social Security number: - -
Sharp Health Plan member ID#:	Phone number: ( )		Birth date (MM/DD/YY): / /
Home address (NOTE: P.O. Box is not allowed.):			
City:	State:		ZIP code:
Services received:			
Date of service (MM/DD/YY): / /	Date discharged from hospital, if applicable (MM/DD/YY): / /		
Physician providing services:	Name of facility where services were performed:		
Referring Sharp Health Plan network physician name:	Travel companion name (if applicable):		

Parent/Guardian (Complete This Section if the Member Is Under 18.)		
First name:	Last name:	Middle initial:
Phone number: ( )		Birth date (MM/DD/YY): / /

Travel Information	
Dates traveled:	
Expenses To Be Reimbursed	**Total Reimbursement or Mileage**
Transportation (airfare, bus, train, taxi, rideshare, rental car)	
Mileage (enter total miles, round trip)	
Hotel	
Meals	
Parking and tolls	

Certification Statement		
I certify that the above information is true and the attached material is correct and unaltered and that the expenses were incurred by the patient named above. I understand all documents submitted become the property of Sharp Health Plan and will not be returned. I understand that if I submit false receipts or fraudulently altered documents, I may be disenrolled from Sharp Health Plan and/or subject to civil or criminal penalties. I authorize the release of any information needed to review or process this request.		
Member's name (Parent/Guardian if child):	Member's signature (Parent/Guardian if child):	Date (MM/DD/YY): / /

If you need assistance, we're here to help.
You can contact Customer Care using the Sharp Health Plan mobile app or by logging in to your Sharp Health Plan online account. We are available to assist you Monday through Friday, 8 a.m. to 6 p.m.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002.

IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.