Travel Benefit Reimbursement Form
Covered Services Restricted by State Law

Instructions

Complete this form and attestation to request reimbursement for travel expenses that are primarily for and essential to obtaining covered services that are restricted or prohibited in your state of residence as a result of state law.

1 Confirm you meet these eligibility requirements:

- Your plan must have this travel benefit. Confirm by referencing your updated plan documents on the member portal, or call Member Services at the number listed on the back of your ID card.
- You must not have access to the covered benefit in your state of residence due to a state law restriction.
- Travel must be primarily for and essential to receiving the covered benefit.
- You must travel at least 100* miles from your residence to receive services.

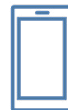
**Some eligibility requirements and benefit limits may vary based on your health plan. Please refer to your plan documents for details about your coverage.*

2 Submit the following to Health Plans, Inc. (HPI) at the address below

Submit to HPI*:

1. This completed and signed reimbursement form, including attestation of eligibility.
2. Proof of payment for travel (e.g. receipts, bills, etc.).

PO Box 5199
Westborough, MA
01581



Reach us by phone at:
800-532-7575
508-792-1188 (fax)

Did you know you can submit your documents online?
It's quick and easy! Simply log in to *My Plan* at **hpiTPA.com**.

**Any missing information may result in delay or denial of the reimbursement.*

NOTE: Members may be entitled to reimbursements for eligible travel expenses such as:
– Coach class airfare transportation
– Lodging at $50 per day or $100 per day if traveling with a necessary companion
– Meals are excluded per IRS guidelines

Reimbursement will be sent to the member at the address the Plan has on record (unless the member is a minor in which case the reimbursement will be sent to the employee).

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Employer Name: ______________________________ **Group Number:** __________________________

Member listed below is receiving covered medical services that are restricted or prohibited in the member's state of residence as a result of state law, and the travel expenses are essential to and primarily for receiving these services. By providing your contact information below, you agree to be contacted by us via email and/or phone regarding your plan benefits and administration.

Member Information

Employee First Name | **Employee Last Name** | **Employee Middle Initial**

Member First Name | **Member Last Name** | **Member Middle Initial**

Street Address

Town/City | **State** | **ZIP Code**

HPI Member ID | **Date of Birth** (mm/dd/yyyy) | **Phone Number** | **Email Address**

Service Information

Please complete the information below:

Place of Service (Check one)	Provider Name	Provider Address	Provider Phone	Dates of Service mm/dd/yyyy
Providers Office				
Clinic				
Hospital/Facility				

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Travel Information

Lodging is reimbursed when medical care is provided by a physician in a licensed hospital or in a medical care facility which is related to, or the equivalent of, a licensed hospital. The below claim and travel information must be related to the member listed above and coincide with travel dates.

		Internal Use Only
Dates of Travel (MM/DD/YYYY- MM/DD/YYYY)		
Total Miles Driven Round Trip[1]		
Cost of Airfare for Member		
Cost of Airfare for Companion[2] (if applicable)		
Cost of All Other Covered Transportation		
Number Nights Lodging[3]		
Total Cost of Lodging[3]		
All Other Travel Costs Excluding meals (i.e. tolls, parking)		

[1] Mileage will be reimbursed at IRS guideline level, currently set at .22 cents per mile, which includes gasoline.
[2] Companion travel will be reimbursed if a companion is necessary to enable the member to receive care (e.g., minor requiring parental consent and/or member requiring sedation for services). **Companions are limited to one** under this benefit.
[3] Lodging will be reimbursed at a maximum of $50 per night or $100 per night if a companion is necessary.

No reimbursement is available for costs already reimbursed through a Flexible Spending Account (FSA) or Health Reimbursement Account (HRA). Expenses for which you are reimbursed under a health plan may be ineligible for tax-free reimbursement under a Health Savings Account (HSA). Questions concerning HSA taxation should be referred by you to a personal tax advisor at your own expense.

Member Signature (Required)

I attest that the above information is true and accurate and that the travel expenses submitted for reimbursement were paid by me in the amount requested as indicated above. I further attest that my employer offers this travel benefit, these travel expenses are primarily for and essential to receiving covered medical services that are restricted or prohibited in my state of residence as a result of state law, and that I had to travel at least 100* miles to obtain these covered services. I further acknowledge that failure to meet these eligibility requirements may result in this reimbursement being considered taxable income, and that I should consult my tax advisor.
I understand that reimbursement payment will be made to the member listed above (unless the member is a minor in which case the reimbursement will be sent to the employee), and will contain information about the service (e.g., termination of pregnancy, gender affirming surgery for minors). I also understand that Health Plans, Inc., as applicable, may request any additional information it deems necessary to verify that the travel expenses were received for the covered purpose and that payment was made.
**Some eligibility requirements and benefit limits may vary based on your health plan. Please refer to your plan documents for details related to your coverage.*

Signature (Employee signature if Member is a minor) **Date Signed (mm/dd/yyyy)**

Let's double-check!

I have completed and signed this form in its entirety.

I have enclosed proof of payment and copies of all receipts for applicable covered services.

I understand that most completed reimbursement requests are processed within 30 days.

Mail this form and proof of payment to HPI:

Health Plans, Inc.
PO Box 5199
Westborough, MA 01581

HPI Online Member Reimbursement Portal:

healthplansinc.com/members/members-secured/