Travel Claim Form

Meritain Health®
an aetna® company

Complete and send to:
Meritain Health
P.O. Box 853921
Richardson, TX 75085-3921
Fax: 1.763.852.5057
Email: west.region.claims@meritain.com

IMPORTANT: Please have the referring physician assist you in completing this form. Then, after you travel, mail or fax this completed form, a completed health claim form and the used airfare ticket stub and any applicable receipts to Meritain Health to obtain reimbursement for your airfare.

EMPLOYEE INFORMATION					
Name (last, first, initial)			Sex	Employer Name	
Home Address			Identification Number	Birthdate	Group Number
City	State	Zip Code	Work Telephone ( )	Home Telephone ( )	

PATIENT INFORMATION			
The patient is:	☐ **The Employee**	☐ **Employee's Spouse**	☐ **Employee's Child**
Patient's Name (last, first, initial)			Sex
Patient's Birthdate			
Name of escort: Relationship to patient: Escort only allowed for the parent or legal guardian of a dependent child under age 18 or an adult accompanying an incapacitated adult (documentation required).			

If traveling with a caregiver, please print a copy of the caregiver medical necessity form. A physician's signature is required on this form to support reimbursement.

TRAVEL REIBURSEMENT		
Is this related to any of the following? Transplant Cancer Treatment		
Total travel costs	Travel Airplane Car Bus Train Other	
Hotel costs		
Gas costs	Rental car	Parking/tolls
Airfare		
Food costs		

By signing below, I am affirming that I have paid for the travel services and am not entitled to reimbursement by any other organization.	
Employee Signature	Date