SmartHealth

Ascension

Travel Benefit Request Form

(Participant must complete a separate form for each applicable dependent.)

Complete this form:

This policy is only applicable to those participants and their dependents when a participant seeks services at an Ascension Network facility or an Ascension approved Transplant Center of Excellence (COE) that are not available at the participants own Health Ministry.

The travel benefit allows for reimbursement of transportation, lodging and meals when a participant seeks services at an Ascension Network facility that are not available at the participants own Health Ministry. There are a limited number of medical conditions that may qualify for a travel benefit. These conditions include **heart procedures, complex joint replacement procedures, pediatric surgeries, and transplants.**

The Ascension Network facility or COE that the participant is incurring services at must be more than 100 miles from the participant's home address and must be the closest Ascension Network facility/COE where the service is available for the participant to be eligible for the travel benefit. These services are subject to eligibility and coverage limitations at the time the medical care is administered. This is not a Guarantee of Benefits. All plan exclusions and limitations will be applied at the time the claim is processed.

This form must be submitted prior to travel expenses being incurred regardless of whether the Inpatient service requires pre-certification.

Participant Name: **Dependent Name:**		**DOB:**
Participant ID number: **How many companions traveling:**		**Ministry:**
Contact Phone Number: ( )	**Address:**	
Are you presently scheduled for any of the following services?		
☐ Elective Surgery *(Heart procedures)* *Procedure Codes:*	Physician Name: Ascension Network Facility: Address: Nature of Surgery: Diagnosis Codes:	Phone: ( ) Date:
☐ Elective Surgery (*Joint Procedures)* *Procedure Codes:*	Physician Name: Ascension Network Facility: Address: Nature of Surgery: Diagnosis Codes:	Phone: ( ) Date:
☐ Elective Surgery *(Pediatric Surgeries)* *Procedure Codes:*	Physician Name: Ascension Network Facility: Address: Nature of Surgery: Diagnosis Codes:	Phone: ( ) Date:
☐ Elective Surgery *(Transplant Procedures)* *Procedure Codes:*	Physician Name: Ascension Network Facility Address: Nature of Surgery: Diagnosis Codes:	Phone: ( ) Date:

Submit your travel benefit request form to:

***Mail**: Smarthealth Travel Benefit Request - PO Box 37705, Oak Park, MI 48237-7705*

***Fax** # 586.693.4346 or **Email**: ACMH-DL-TravelBenefitRequest@ascension.org*

For questions please call (888) 492-6811