

Medical Travel Reimbursement Form



Please complete this form for reimbursement for certain travel expenses related to obtaining medical services. To be eligible, your employer must opt into this benefit.

EMPLOYEE INFORMATION (POLICYHOLDER)

Employee Full Name:	Member ID # (LOCATED ON FRONT OF MEDICAL ID CARD):	Birth Date:
Street Address:		Apt/Unit#:
City:	State:	Zip:
Employer Name:	Employer Group Number:	

CLAIM INFORMATION

Member Full Name (ENTER THE NAME OF THE PERSON THE CLAIM IS FOR):	Member ID # (LOCATED ON FRONT OF MEDICAL ID CARD):	Birth Date:
This claim reimbursement is for (choose one)		
EMPLOYEE (POLICY HOLDER)	SPOUSE (OF POLICY HOLDER)	Dependent
		EX-SPOUSE
		OTHER (SPECIFY)

TRAVEL INFORMATION

Did you travel with a companion? Your companion's travel costs will also be reimbursed if the companion's presence is necessary for you to receive the medical services. Please include their costs in the totals below.	Y	N
	Date of Covered Service:	

SAVE AND ATTACH ALL OF YOUR RECEIPTS, AND FILL OUT THE FOLLOWING AS APPLICABLE

Dates of travel*	Service Location	Total Miles Driven (Round Trip)	Cost of Airfare	All Other Covered Transportation	Lodging	
FROM:	FROM:	MILES:	\$	\$	Average cost of lodging per night	\$
TO:	TO:				Number of nights	
					Total lodging cost	\$

*PLEASE NOTE: Submission dates should not be prior to reproductive travel plan benefit effective date

IMPORTANT INFORMATION & REMINDERS / AUTHORIZATION & SIGNATURE

- Confirm all receipts have been attached with form when submitting.
- Reimbursement may be considered taxable income, so you should consult your tax advisor.
- Certification and Authorization (This form must be signed and dated below.)
- Submit completed form and all required documentation to GBA Medical, Dental, and Vision Document Submission Portal under the "Medical" option.

I certify that the information provided in support of this submission is complete and correct, and that I have not previously submitted for these purchases. I understand that Great Bay Administrators (GBA) may require proof of payment for a reimbursement decision. I authorize the release of any information about purchases to Great Bay Administrators (GBA).

EMPLOYEE OR MEMBER SIGNATURE	DATE
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PLEASE RETURN COMPLETED FORM TO:

Great Bay Administrators, 37 Industrial Drive Exeter, NH 03833,
or submit through our secure portal