HCA Healthcare
Behavioral Health
TRAVEL & LODGING EXPENSE REIMBURSEMENT FORM
Processor: Sort as NON-KEYABLE

Employee 3-4 ID#	Employee Address (Please Print)	City	State	Zip
Patient last 4 SSN#	Patient Address (Please Print)	City	State	Zip
XXX-XX- __ __ __ __				
Patient Name	Patient Date of Birth	Contact Phone Number		

Today's Date	First Date of Travel	Last Date of Travel	First Date at HCA Healthcare Facility	Last Date at HCA Healthcare Facility

HCA Healthcare Facility Name	Facility City	Facility State

Patient Signature (If applicable Parent/Guardian Signature)	

TRAVEL EXPENSE DETAILS- refer to program description for eligible expenses

Date of Expense	Type of Expense (Hotel, Taxi, Parking ,etc.)	Name of Vendor	Amount

*For personal car use, enter "personal car" as expense type and the number of miles in the amount field. Mileage is reimbursed according to the Medical Mileage rate set by the IRS each year.
*For Lodging expenses, enter all eligible expenses for each date as one amount for that date , including any taxes and fees, as itemized on receipt.

Send Claims To:

Optum Behavioral Health
c/o HCA Healthcare
PO BOX 30760
Salt Lake City, UT 84130

INSTRUCTIONS:

- Make copies of all receipts and this form for your records
- This form must be complete. Incomplete forms will not be processed.
- Enclose this form and all original receipts into an envelope and mail to address
- Do not staple, tape , glue or affix receipts to form in any way.
- Additional expense items can be written on back of form
- Please allow 6-8 weeks for processing
- Call for questions : 877-950-5075