Family and Friends
Reimbursement Request

Transportation Reimbursement Instructions

Dear Well Sense Health Plan Member,

To get paid back for rides or public transportation to covered medical appointments, please fill out the attached form and mail it along with any required receipts within 30 days of your trip. Well Sense transportation will pay you back for the amount approved by Well Sense Health Plan within 30 days of receipt of the form.

Member Reimbursement Guidelines:

- Members should call Well Sense transportation 48 hours before a routine appointment to request reimbursement approval. Please call before the appointment for all other trips if they are urgent.
- Members must be traveling to and/or from an approved service. Pick up location must be from residence on record or an approved alternate address.
- Members or their driver **must submit a completed form to Well Sense within 30 days to be reimbursed.**

How to complete:

- When you call 844-909-7433, we will give you a Trip Order ID number, you must place the trip number on the form.
- You must submit this form in order to be reimbursed.
- You must provide all other copies of receipts in order to be reimbursed (examples: public transit, parking or tolls).
- You will be reimbursed at the current reimbursement rate of $0.41 per mile.
- An authorized medical professional must sign the form (examples include doctors, nurses, therapists, medical assistants, or front office staff).
- Mail or fax the form and receipts within 30 days of your appointment to:

  Well Sense
  c/o One Call
  P.O. Box 896
  Elk Grove Village, IL 60009-0896
  Fax: 1.877.674.7588

Payments will be issued within 30 days of receipt of completed forms. If forms are incomplete or any information is missing, your request for reimbursement may be denied.

Need help or have questions?
Contact the Well Sense Transportation Department at 844-909-7433.

Thank you,
Well Sense Health Plan

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Transportation Reimbursement Form

Please review the attached letter for instructions on how to complete this form. For help with this form contact 844-909-7433

Member Information	First Name	Last Name		Middle Initial
	Member ID	Date of Birth	Phone Number	Trip Order ID
	Street Address	City	State	Zip
Mailing or Pay-To Information	First Name	Last Name	Relationship to Member	
	Street Address	City	State	Zip
Trip 1 Information	Total Miles:	Appointment Date:	Approved Mileage Amount: $	
	Beginning Address	Ending Address		
	Total Parking Amount: $	Total Toll Amount: $	Total Amount: $	
Trip 2 Information	Total Miles:	Appointment Date:	Approved Mileage Amount: $	
	Beginning Address	Ending Address		
	Total Parking Amount: $	Total Toll Amount: $	Total Amount: $	
Trip 3 Information	Total Miles:	Appointment Date:	Approved Mileage Amount: $	
	Beginning Address	Ending Address		
	Total Parking Amount: $	Total Toll Amount: $	Total Amount: $	
Tolls or Public Transportation Expense		☐ Car ☐ Public Transit		
Medical Professional Info Each service date must have a medical staff signature to get payment approval	***NOTE:*** *I certify that the member was seen by this medical office, on the date or dates referenced in the trip section above, for a Medicaid covered service.*			
	Printed Name	NPI #		
	Signature	Phone #		
	Title	Date		
Member Signature	*I hereby certify that all of the information given above is true and correct.*			
	Printed name	Date		
	Signature	Phone #		

20-0004

Last revised April 2020
This form supersedes all previous versions

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