



### WVCHIP Transplant Reimbursement

Member's (Child) Name: \_\_\_\_\_  
Last First Middle

Identification Number: \_\_\_\_\_ Member Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Member's Sex:  Male  Female

Mileage: \_\_\_\_\_

Starting Location/Address: \_\_\_\_\_

Ending Location/Address: \_\_\_\_\_

Round Trip?  Yes  No

Lodging: \_\_\_\_\_ (total) Meals: \_\_\_\_\_ (total – up to \$30 per day/person)

I certify that the above is correct and that I am claiming benefits only for charges incurred by the patient named above. I further authorize release of any medical information necessary to process this claim.

Signature of Member's Parent/Guardian/Representative: \_\_\_\_\_

Date: \_\_\_\_\_

Itemized bills must accompany this claim form. These bills must include the following information:

1. Name of child covered by WVCHIP
2. The WVCHIP Policyholder's identification number
3. The nature of the illness or injury
4. Date(s) of service
5. A complete description of each service
6. The amount charged for each service
7. Diagnosis and procedure codes for each illness, condition and procedure
8. The provider's name, address and NPI number

**Mail to: The Health Plan, 1110 Main Street, Wheeling, WV 26003**

If you have questions, please call THP's Customer Service toll-free at: 1.888.613.8385 (TTY:711)