INHIBITOR SUPPORT
MEDICAL TRAVEL REIMBURSEMENT FORM

Instructions:
Please complete this form and return it to HFA within 30 days of the meeting or event. All expenses must include itemized, detailed receipts.

Meeting / Event name _____ Date(s) _____

Caregiver(s) _____

Patient can bring either one (1) or two (2) caregivers.

TRAVEL

Taxi/Shuttle $_____

Airfare (Economy) $_____

Baggage Fees $_____
Limit one (1) bag per person

Train (Coach) $_____

Rental Car $_____

Personal Car $_____

Automobile _____ at 17¢ per mile $_____
Include a copy of map directions and mileage

Parking $_____
Self-parking only, no valet.
Parking is only reimbursable for hotel, airport or hospital.

TRAVEL SUBTOTAL $ _____

ACCOMMODATIONS

Hotel $_____
One (1) room only

Food $_____
Meals during hosptal stay allowed
$40 per day maximum

Other $_____

ACCOMMODATIONS SUBTOTAL $ _____

TOTAL REIMBURSEMENT AMOUNT REQUESTED $ _____

Please complete: HFA will provide reimbursement via check to household within 30 days of receipt of this completed form.

Check payable to _____

Address _____ City _____ State _____ Zip _____

Primary phone _____ Email _____

Signature of Applicant or Parent/Guardian _____ Date _____

- *Any expenses that are thought of as "unreasonable" by HFA will not be reimbursed*
- *Reimbursements will not be given for upgrades in ground or air transportation*
- *Applicants must submit itemized receipts for all expenses.*

Please submit this form to: 999 North Capitol Street NE, Suite 201, Washington, DC 20002,
fax: 202.675.6983, email: *helpinghands@hemophiliafed.org*