



# 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	ACCOMMODATIONS
Taxi/Shuttle \$ _____	Hotel \$ _____ <i>One (1) room only</i>
Airfare (Economy) \$ _____	Food \$ _____ <i>Meals during hospital stay allowed \$40 per day maximum</i>
Baggage Fees \$ _____ <i>Limit one (1) bag per person</i>	Other \$ _____
Train (Coach) \$ _____	
Rental Car \$ _____	
Personal Car \$ _____	
Automobile _____ at 18¢ per mile \$ _____ <i>Include a copy of map directions and mileage</i>	
Parking \$ _____ <i>Self-parking only, no valet. Parking is only reimbursable for hotel, airport or hospital.</i>	
<b>TRAVEL SUBTOTAL \$ _____</b>	<b>ACCOMMODATIONS SUBTOTAL \$ _____</b>

**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.