

## Medicaid Overnight Reimbursement Form

This form must be submitted within six (6) months from the date services were received in order to be considered for reimbursement. A decision on the reimbursement request will be made within (ninety) 90 days of receiving the completed form and receipt(s).

Any additional services that are received that go over the approved benefit(s) will be the responsibility of the member.

### Step 1: Member Information

1. Member's Humana ID (HUMID) Number is on the Member ID Card
2. All boxes must be filled out
3. Please submit one (1) form per member

Member Name	HUMID (Humana ID)	Medicaid ID
Address		
City	State	ZIP Code
Signature	Print name of Guardian or responsible party (For minors only)	

### Step 2: Receipt Information

1. Include all copies of the original receipt(s) AND proof of payment for the benefit. Tape receipt(s) to a separate page and submit with this reimbursement form.
2. Lodging receipt(s) must show be a breakdown of all cost. If the receipt(s) is missing any of this information, please ask the Lodging Company for a printout that includes the breakdown of information.
3. Restaurant receipt(s) must show the restaurant name, date, time (if available), and dollar amount.
4. Remember to keep a copy of the completed claim form and receipt(s) for your records.

Lodging/Restaurant Overnight Benefit	Date
Lodging/Restaurant Name	
City, State	
Reimbursement Amount Requested	Receipt Included    Yes    No
Comments	

Lodging/Restaurant Overnight Benefit	Date
Lodging/Restaurant Name	
City, State	
Reimbursement Amount Requested	Receipt Included    Yes    No
Comments	

Lodging/Restaurant Overnight Benefit	Date
Lodging/Restaurant Name	
City, State	
Reimbursement Amount Requested	Receipt Included    Yes    No
Comments	

Lodging/Restaurant Overnight Benefit	Date
Lodging/Restaurant Name	
City, State	
Reimbursement Amount Requested	Receipt Included    Yes    No
Comments	

Lodging/Restaurant Overnight Benefit	Date
Lodging/Restaurant Name	
City, State	
Reimbursement Amount Requested	Receipt Included    Yes    No
Comments	

### Step 3: Submit With Signature

- Please submit within six (6) months from the date of service(s)
- Once all sections of this form are completed, please sign and date. The members, or legal guardians, signature states that all information on this form and the attached receipt(s) submitted is correct.

**For fastest consideration, return this completed form via email, or fax with all copies of the original receipt(s) to:**

Email: [ExpandedBenefitsreimbursement@humana.com](mailto:ExpandedBenefitsreimbursement@humana.com)

Fax: 855-510-0041

#### Mail Address:

**Humana Travel Benefit c/o Expanded Benefits Administrator**

P.O. Box 3114

Louisville, KY 40201

**For the purposes of reimbursement see rates please see below**

Benefit	Reimbursement Rate	Limitations/Exclusion
Lodging	\$80 or less per night for one room	Anything paid over the benefit amount will be the responsibility of the member.
Breakfast	\$6 per member and 1 other person	
Lunch	\$11 per member and 1 other person	
Dinner	\$19 per member and 1 other person	

Human Healthy Horizon in Florida reimburses for Lodging accommodations and a per diem for meals for all overnight trips at the Florida government rate in accordance with Section 112.061.F.S\*



\*"Non-Emergency Transportation Services," Florida Medicaid, last accessed Jan. 05, 2022, [https://ahca.myflorida.com/medicaid/review/Specific/59G-4.330\\_NET\\_Coverage\\_Policy\\_Adoption.pdf](https://ahca.myflorida.com/medicaid/review/Specific/59G-4.330_NET_Coverage_Policy_Adoption.pdf).

## Notice of Non-Discrimination

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services.

Humana Inc. provides free language assistance services to people whose primary language is not English, people with disabilities or who need reasonable modifications or free auxiliary aids and services to communicate effectively with us. These services include qualified interpreters including sign language and written information in other languages and formats (large print, audio, accessible electronic formats, other formats).

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **800-477-6931 (TTY: 711)**, Monday through Friday, from 8 a.m. to 8 p.m., Eastern time. If you believe that Humana, Inc. has not provided these services or you feel you have experienced discrimination, you can file a grievance in person or by mail, or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **800-477-6931 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019, 800-537-7697 (TDD)**.

Auxiliary aids and services, free of charge, are available to you. **800-477-6931 (TTY: 711)**, Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern time.

**English:** Call the number above to receive free language assistance services.

**Español (Spanish):** Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

**French Creole (Haitian Creole):** Kreyòl Ayisyen (French Creole) Rele nimewo ki e dike anwo a pou resevwa sèvis éd gratis nan lang.

This notice is available at **[Humana.com/FloridaAccessibility](https://www.humana.com/FloridaAccessibility)**.

Humana Healthy Horizons in Florida is a Medicaid product of Humana Medical Plan, Inc.

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**Français (French):** Appelez le numéro ci-dessus pour recevoir des services gratuits d'assistance linguistique.

**Italiano (Italian):** Chiamare il numero sopra indicato per ricevere servizi di assistenza linguistica gratuiti.

**Русский (Russian):** Позвоните по вышеуказанному номеру, чтобы получить бесплатную языковую поддержку.

**Tiếng Việt (Vietnamese):** Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

**Português (Portuguese):** Ligue para o número acima para receber serviços gratuitos de assistência no idioma.

**繁體中文 (Chinese):** 您可以撥打上面的電話號碼以獲得免費的語言協助服務。

**Tagalog (Tagalog – Filipino):** Tawagan ang numero sa itaas para makatanggap ng mga libreng serbisyo sa tulong sa wika.

**العربية (Arabic):** اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

**Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

**한국어 (Korean):** 무료 언어 지원 서비스를 받으려면 위 번호로 전화하십시오.

**Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, należy zadzwonić pod wyżej podany numer.

**ગુજરાતી (Gujarati):** મફત ભાષા સહાય સેવાઓ મેળવવા માટે ઉપર આપેલા નંબર પર કોલ કરો.

**ภาษาไทย (Thai):** โทรไปที่หมายเลขด้านบนเพื่อรับบริการช่วยเหลือด้านภาษาฟรี