

**CENTERS OF EXCELLENCE
REQUEST FOR TRAVEL/LODGING REIMBURSEMENT**

NOTE: PRIOR AUTHORIZATION IS REQUIRED FOR THIS TRAVEL/LODGING BENEFIT TO ENSURE PAYMENT.

Please complete this form and return to:

Cliffs Natural Resources Inc.
200 Public Square, Suite 3300
Cleveland, Ohio 44114
ATTN: Benefits Department
Phone Number in event of questions (216) 694 – 5924
Secure Fax Number (216) 694 – 5381 or E-mail Address Brenda.Gainer@CliffsNR.com

Section A: Employee Information

Name: _____	Date-of-Birth (MM/DD/YYYY): ___/___/___
Address: _____	Social Security Number: _____ - _____ - _____
City, State & Zip: _____	Group Number (on ID Card): _____
Phone Number(s): _____	Identification Number (on ID card – include all letters & numbers): _____
E-Mail Address: _____	

Section B: Dependent Information (Where Applicable)

* Group and ID Number only if different than Employee

Name: _____	Date-of-Birth (MM/DD/YYYY): ___/___/___
Relationship: _____	Social Security Number: _____ - _____ - _____
*Group Number (on ID Card): _____	*Identification Number (on ID card – include all letters & numbers): _____

Section C: Purpose for the Travel (Please specify below.)

Managed care participants may elect to utilize “Centers of Excellence” for medical services or procedures that are difficult, costly or specialized and where such treatment would be likely to reduce costs or improve the outcome. Centers of Excellence are health care institutions that have gained professional recognition through specialized clinical expertise and equipment acquisitions, and are able to provide major resource-intensive procedures in a more effective and efficient manner than may be possible elsewhere in the region.

Please briefly explain medical condition(s) and include name(s) of any referring physician(s):

Section D: Who Can Release the Information: the person/company who is allowed to release the information?

Anthem Blue Cross and Blue Shield and its Business Associates

United Health Care

Other: _____

Other: _____

Other: _____

Attending Physician(s): Please include any specialist(s) that have been seen regarding this medical condition(s).

Name: _____

Specialty: _____

Address: _____

City, State & Zip: _____

Phone Number: _____

Name: _____

Specialty: _____

Address: _____

City, State & Zip: _____

Phone Number: _____

Section E: Who Can Receive the Information: person/company/agency or facility who is allowed to receive the information.

Cliffs' Manager(s) of Health and Welfare Benefits

Cliffs' Medical Director

Yes **No** USW Contract Coordinator

Yes **No** USW Local Union President

Yes **No** USW Staff Representative

Yes **No** USW Benefits Technician

Yes **No** CMO Managed Care Oversight Committee Members

Additional Representatives as Named:

Section F: What Information is Being Released: Indicate what information you are authorizing to be released

Any reasonable information necessary to substantiate the need to travel to a Center of Excellence (per the criteria of Section C above) for the following condition.

Additional information to be released:

Information NOT to be released:

Section G: Details of Travel

If prior authorization is obtained or a denial is successfully appealed, transportation for the participant and a family member to the Center of Excellence will also be paid for, including lodging for the family member.

Center of Excellence being referred to: _____

Centers of Excellence include the facilities outlined in the PIB, as well as the Blue Distinction facilities contracted by Anthem.

Miles to facility (only travel in excess of 150 miles one way may qualify, travel in excess of 300 miles one way may require alternative travel arrangements, i.e. by commercial plane or rental car): _____

Departure Date: _____ Return Date: _____

Appointment Date(s): _____

Additional Information: _____

Is this the first visit to this physician for an additional medical opinion? Yes No

Is this request for a treatment plan with continued care? Yes No

If this is for ongoing treatment, please supply the details of this treatment plan, including nature of treatment, length and expected outcomes. _____

Note: You may attach a letter from Attending Physician outlining the reason for utilizing a Centers of Excellence, if applicable.

PRIOR AUTHORIZATION IS REQUIRED IN ORDER TO RECEIVE THIS BENEFIT FOR EACH VISIT TO THE CENTERS OF EXCELLENCE, UNLESS OTHERWISE SET FORTH IN WRITING FROM THE COMPANY. FAILURE TO OBTAIN THIS PRIOR AUTHORIZATION BEFORE TRAVEL HAS COMMENCED MAY BE A FORFEIT OF THIS BENEFIT!

- a. Emergency travel will be given priority processing. Please allow two weeks for authorization on non-emergency travel, provided all necessary paperwork is received and completed thoroughly.
- b. Provided travel is approved, member must make arrangements for all medical records and/or test results, x-ray readings to be delivered to the specialist prior to your visit. When additional tests may be required, best efforts need to be made to be sure that scheduling is made to accommodate for those services to be performed on the same day. In an effort to assist the members with receiving the highest quality of care in the most efficient time manner Cliff's Medical Director may be requested by you to assist in the coordination of care.
- c. Travel benefits if approved will be for the reasonable cost to get the member and their companion from the member's residence to the Center of Excellence and back to the member's residence.

Section H: Expiration Date:

If not previously revoked, this authorization will terminate on the earliest of the following dates:

(1) the date the individual's coverage ends (only if disclosure requested by insurance company); or

(2) one year from the signature date below; or

(3) upon the following date, event or condition: _____

*The party identified in Section D must be notified **in writing** of the event/condition to cancel authorization.*

Section I: Signature:

Your enrollment in a health plan, eligibility for benefits, processing and payment of claims, or treatment is not conditioned on giving this authorization. This authorization form applies only to travel/lodging reimbursement.

A copy of this authorization is available to you, or to your personal representative, upon request and will serve as the original.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual receiving care, complete the following and attach a copy of the representative's authority to sign this form (e.g. copy of Health Care Power of Attorney, Executor/Administrator of an estate):

Personal Representative's Name: _____

Relationship to Individual: _____

You will receive a written response regarding the approval or denial of this request from Cliff's within fourteen days. If this is not sufficient due to medical and/or travel plans please call the number at the top of this form and speak to one of our representatives.

Use the Enclosed Travel Reimbursement Form for reimbursement request once travel has commenced (Attachment A).

**CENTERS OF EXCELLENCE
REQUEST FOR TRAVEL/LODGING REIMBURSEMENT FORM**

Attachment A

<p>Section A: Employee Information</p> <p>Name: _____</p> <p>Date-of-Birth (MM/DD/YYYY): ___/___/____</p> <p>Address: _____</p> <p>City, State & Zip: _____</p> <p>Phone Number(s): _____</p> <p>E-Mail Address: _____</p>	<p>Dependant Information</p> <p>Name: _____</p> <p>Date-of-Birth ___/___/____</p> <p>Relationship: _____</p>
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**Section B:
Travel/Lodging Detail**

Date of Travel	# of Miles	Starting Location	Final Destination	Reason for Travel
Total				
Date(s) of Lodging	Cost	Hotel Name	Hotel Location	Reason for Lodging
Total				
Date(s) of Rental/Flight/Taxi	Cost	Company Name		Reason For Alternate Transportation
Total				

Please attach copies of all lodging, gas, airfare, taxi and/or rental car receipts to this form.

NOTE: Please retain copies for your files.

Additional Travel/Lodging Detail

Date of Travel	# of Miles	Starting Location	Final Destination	Reason for Travel
Total				
Date(s) of Lodging	Cost	Hotel Name	Hotel Location	Reason for Lodging
Total				
Date(s) of Rental/Flight/Taxi	Cost	Company Name		Reason For Alternate Transportation
Total				