TEXAS Health and Human Services

Kidney Health Care
Travel Claim Form for Home Dialysis and Kidney Transplant Patients

Client Information		
Last Name	First Name	Middle Initial
Phone Number	Social Security Number (optional)	KHC Number

Trip Information

Provide your monthly travel details by filling in all four columns of this table. For the last column, choose the code from the list below that best describes the reason for your trip. You will only be reimbursed for four trips you already traveled per month which is related to end-stage renal disease or kidney transplant.

Access Surgery	**AS**	Epogen	**EP**	Peritoneal Clinic Visit	**PC**
Access Complication	**AC**	Lab tests, X-rays or other	**XR**	Tests before your transplant	**BT**
PD Support	**PD**	Nephrologist Visit	**NE**	Transplant Surgery	**TS**
Check-up after your transplant	**AT**				

If the reason for your trip is not on the list, then: (1) Check the box marked 'Other' and (2) Fill in the back of this form.

Date MM/DD/YY	**Name of Person or Place You Went to See**	**Full Location Address**	**Reason for Trip** (Use a code from list above or choose 'Other')
			_____ ☐ Other (Fill in the back)
			_____ ☐ Other (Fill in the back)
			_____ ☐ Other (Fill in the back)
			_____ ☐ Other (Fill in the back)

Client Acknowledgement

I agree that each trip shown above was for travel and mileage that is allowed. I also agree that no other agency can pay me back for the trip and mileage. I understand that if I hold back any facts or submit information that is not true, I may be doing something that is against the law, which in that case I could lose my benefits, have to pay money back, or face legal actions.

Client Signature	Witness Signature (if client cannot sign)

Kidney Health Care • MC 1938 • PO Box 149347 • Austin, Texas 78714-9347
1-800-222-3986 • khc@hhsc.state.tx.us

Last Name	First Name	Middle Initial	KHC Number

Fill in the blanks below only if you have checked the box 'Other' on the other side of this form. KHC needs to know some things in order to figure out if it can pay for your trip(s). If you have trouble filling this part out, you can ask for help from your doctor or someone else from where you get your care.

If KHC has already reviewed and approved your travel for this condition, you only need to fill out Field number 3.

1. Date of Trip(s):

2. Where did you go? Place or Doctor's Name(s), Street Address(es), and Phone Number(s):

3. Describe how the trip is related to your end-stage renal disease or kidney transplant:

KHC will do a medical review with this information. KHC may call your doctor(s) for more information. KHC will tell you its decision after it does the review. If KHC decides that the trip(s) are related to end-stage renal disease or a kidney transplant, your KHC file will be updated. This will allow you to make future trips related to the condition.

For Use By KHC Reviewer ONLY			
Reviewer	Date	Allow Trip(s)	Disallow Trip(s)
Comments:			

Notice about Your Right to Privacy

Except in some cases, you have the right to ask for and know the information the State of Texas has about you. You can ask for it at any time. You can get it and make sure it is right. You have the right to ask the state agency to correct anything that is wrong. See http://hhs.texas.gov for more information on Your Right to Privacy. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)