encova INSURANCE

CLAIMANT TRAVEL VOUCHER

Return completed form to:
Encova Insurance
P.O. Box 3151
Charleston, WV 25332-3151
Or fax to: 877-898-6980

TRAVEL VOUCHERS MUST BE FILED WITHIN SIX MONTHS OF THE DATE OF TRAVEL

1. Claimant name (first, middle, last)		2. Claimant address (street or P.O. box, city, state, ZIP)
3. Claimant Social Security number	4. Date of injury	5. Claim number
6. Provider name (please print)		7. Authorization number
8. Address of point of departure (need physical address or closest route number)		9. Address of point of destination
10. Time of departure ☐ AM ☐ PM	11. Time of return ☐ AM ☐ PM	12. Purpose of travel

Medical procedure codes to be used below in column 14.

Code	Description	Code	Description	Code	Description
X0910	Hotel/motel	X9910	Mileage (occupational pneumoconiosis)	X0930	Air travel
X0915	*Meals	X0920	Mileage	X0935	Bus/train
X9911	*Meals (occupational pneumoconiosis)	X0925	Parking/tolls	X0300	Voc. rehab (mileage for retraining)
X0922	Reimbursement for IME travel	X0921	Claimant travel 2nd physician same day mileage	FEDTR	Federal black lung - travel

Hotel/motel stay and air/bus/train travel require prior authorization. Receipts must be attached when seeking reimbursement for all services other than mileage.
*Meals are reimbursed for authorized OVERNIGHT travel only.

13. Date	14. Procedure code	15. Description	16. Units/quantity	17. Charges

18. Service provider signature	19. Claimant signature	Date	20. Total charges

The present employer is to complete the section below only if the claimant has lost wages in order to appear for a medical examination requested by Encova Insurance. (Not for routine medical treatment)

21. Employer business name, address and phone number			
22. Date(s) of lost wages	23. Number hours of wages lost	24. Hourly wage	25. Amount of lost wages
		x	=
		x	=
Employer signature	Title		Date

INSTRUCTIONS FOR COMPLETING CLAIMANT TRAVEL VOUCHER

Each travel voucher can contain expenses for only ONE CLAIM and visits to ONLY ONE SERVICE PROVIDER. If information is wrong, missing or illegible, the form will be returned to you.

1. **CLAIMANT NAME:** Your full name as it appears on the letters we send you.
2. **CLAIMANT ADDRESS:** Your full mailing address including ZIP code.
3. **CLAIMANT SOCIAL SECURITY NUMBER:** Your Social Security number.
4. **DATE OF INJURY:** In an occupational pneumoconiosis or disease claim, this is the date of last exposure.
5. **CLAIM NUMBER:** The number assigned to your claim by Encova Insurance.
6. **PROVIDER'S NAME:** The service provider that you went to see.
7. **AUTHORIZATION NUMBER:** Services that require prior authorization must have this number. This number appears on the letter sent to you granting authorization for the service or procedure. There is no number for an OP Board examination.
8. **ADDRESS OF THE POINT OF DEPARTURE:** Encova reimburses for mileage from the claimant's residence. This street address must be written completely including street, city, state, and ZIP code. (No P.O. boxes)
9. **ADDRESS OF POINT OF DESTINATION:** This is the complete address of the service provider's office to which you traveled. Include the street, city and ZIP code. (No P.O. boxes)
10. **TIME OF DEPARTURE:** This is the time you left your residence (the address of the point of departure).
11. **TIME OF RETURN:** This is the time you returned to your residence.
12. **PURPOSE OF TRAVEL:** The reason you made the trip.
13. **DATE:** The date of the travel, meal, lodging etc. Put only one type of expense on each line. Note: Travel vouchers must be filed with Encova within six months of the date of travel.
14. **PROCEDURE CODE:** The code list is on the front of the form in the first shaded area. Find the code for the expense for which you are billing and put in this block.
15. **DESCRIPTION:** Explain the type of expense for which you are billing.
16. **UNITS:** The number of miles traveled.
17. **CHARGES:** The total charges for the line item.
18. **SERVICE PROVIDER SIGNATURE:** All vouchers must be signed by the service provider you went to see.
19. **CLAIMANT SIGNATURE AND DATE:** This is your signature and the date that you are sending this form to us.
20. **TOTAL CHARGES:** This is the total of all amounts in the "charges" column.
21. **EMPLOYER BUSINESS NAME, ADDRESS AND PHONE NUMBER:** This is the employer's information.

CLAIMANT: DO NOT FILL OUT BLOCKS 22 through 26. This section is completed by your current employer if you missed work and lost wages because you were attending a medical examination requested by Encova.

After this form is completed, make a copy of this form and any receipts for your records and send the form to Encova at the address listed on the front of the form.

***NOTE:** Meal reimbursement will be made only if the claimant has been authorized for overnight travel.

***NOTE:** Lost wages will be reimbursed only when the claimant appears for a medical examination requested by Encova.