TEXAS Health and Human Services

Form 3093
July 2022-E

Kidney Health Care (KHC)

Travel Claim for Home Dialysis and Kidney Transplant Patients

Client Information

Last Name	First Name	Middle Initial
Area Code and Phone No.	Social Security No. *(optional)*	KHC No.

Trip Information

Provide your monthly travel details by filing 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 are related to end-stage renal disease or kidney transplant.

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

If the reason for your trip is not on the list, then check the box marked “Other” and 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 the list above)*	**Other**
				☐
				☐
				☐
				☐

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 could result in losing my benefits, having to pay money back or facing legal actions.

Client Signature _____ **Witness Signature** *(if client cannot sign)* _____

Mail this form to Kidney Health Care, Mail Code 1938, P.O. Box 149030, Austin, TX 78714-9947 or Fax to 512-776-7162.

Last Name	First Name	Middle Initial	KHC No.

Fill in the blanks below only if you have checked the box “Other.” KHC needs this information to determine if we can pay for your trip(s). If you have trouble filling out this part of the form, you can ask your doctor or someone else from where you get your care to assist you.

If KHC has already reviewed and approved your travel for this condition, you only need to fill out Field No. 3.

1. Date of trip(s):

2. Where did you go? Place or doctor's name(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 the decision after doing 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 KHC Reviewer Use 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 and make sure the information is correct. 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)

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