TEXAS Health and Human Services

Form 3093
May 2024

Kidney Health Care (KHC) Program

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 Client ID

Contact the KHC Program at 800-222-3986 if your home or mailing address has changed.

Trip Information

Provide your monthly travel details by completing all four columns of this table for each trip. On the "Reason for Trip" column, choose the code from the list below that best describes the reason for your trip. If the reason for your trip is not on the list, check the box "Other" and complete the back of this form.

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 - Peritoneal Dialysis Support
NE - Nephrologist Visit
TS - Transplant Surgery
AT - Check-up after your transplant
TR - Peritoneal Training
RX - ESRD Pharmacy Pickup

Make sure to use one claim form for each calendar month

You will only be paid for **four eligible trips** traveled per month that are related to end-stage renal disease or kidney transplant.

Trip	**Date** MM/DD/YY	**Facility or Name of Physician**	**Facility Address** Street, City, State, ZIP Code	**Reason for Trip** (Use a code from the list above)	**Other**
1					☐
2					☐
3					☐
4					☐

Client Acknowledgement

I agree that each trip shown above was for allowed travel and mileage. 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.

Client Last Name	Client First Name	Client Middle Initial	KHC Client ID

Only complete the boxes below if you checked "Other" for any trip(s) on page 1. The information provided below will help to determine if trips are eligible for payment. If you need assistance filling out this section of the form, the physician where you received your services.
If KHC already reviewed and approved your travel for this condition, you only need to fill out Field No. 3.

1. Date of trip(s):

2. Facility or name of physician(s):

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

KHC will do a medical review with the provided information and may contact your physician(s) for more information. KHC will decide if the trip(s) are related to end-stage renal disease or a kidney transplant, and your record 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. Review 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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