[YOUR HEALTHCARE ORGANIZATION]

123 Healthcare Avenue

Cityville, State 12345

Phone: (555) 123-4567

Email: [reimbursements@healthcareorg.com](mailto:reimbursements@healthcareorg.com)

Date: May 15, 2025

Patient Name: [Patient Name] Patient ID: [Patient ID Number] Claim Reference: TR-2025-45678

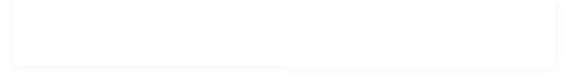
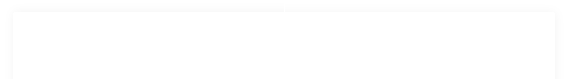
RE: DECISION ON TRAVEL REIMBURSEMENT REQUEST

Dear [Patient Name],

Thank you for submitting your request for travel reimbursement related to your medical appointment at [Medical Facility Name] on [Date of Service].

# DECISION

After careful review of your request and supporting documentation, we are pleased to inform you that your travel reimbursement request has been APPROVED for the following amounts:



|  |  |  |
| --- | --- | --- |
| Expense Category | Amount Requested | Amount Approved |
| Mileage (180 miles @ $0.65/mile) | $117.00 | $117.00 |
| Lodging (1 night) | $125.00 | $125.00 |
| Meals | $45.00 | $35.00\* |
| Parking Fees | $12.00 | $12.00 |
| TOTAL REIMBURSEMENT |  | $289.00 |

\*Meal reimbursement is limited to $35.00 per day per our policy guidelines.

# EXPLANATION

Your request meets our eligibility criteria for travel reimbursement as:

1. The medical service you received is not available within 50 miles of your residence
2. The treatment was medically necessary and pre-authorized
3. You provided all required receipts and documentation
4. Your travel occurred within the covered timeframe related to your appointment

# PAYMENT INFORMATION

A check for the approved amount will be mailed to your address on file within 14 business days. Alternatively, if you have set up direct deposit for reimbursements, the funds will be deposited into your account within 5-7 business days.

# APPEALS PROCESS

If you disagree with any aspect of this decision, you have the right to appeal within 30 days of the date of this letter. To initiate an appeal, please submit:

A written statement explaining why you believe the decision should be reconsidered

* + Any additional supporting documentation Your appeal request form (enclosed)

Appeals can be submitted via mail to the address above, Attention: Reimbursement Appeals Department, or via email to [appeals@healthcareorg.com](mailto:appeals@healthcareorg.com)

# CONTACT INFORMATION

If you have any questions about this decision or the reimbursement process, please contact our Member Services department at (555) 123-4567, Monday through Friday, 8:00 AM to 5:00 PM.

Sincerely,

[Administrator Name]

Travel Reimbursement Coordinator [YOUR HEALTHCARE ORGANIZATION]

IMPORTANT NOTICE: This decision letter contains personal and confidential information. Please store it securely with your medical records. This reimbursement decision is based on the information available at the time of review and the current policies of [YOUR HEALTHCARE ORGANIZATION].