



**DEPARTMENT OF VETERANS AFFAIRS  
VA Manchester Health Care System  
718 Smyth Rd  
Manchester, NH 03104**

Mail Stop: 00Travel

**Instructions for Beneficiary Travel Reimbursement for Care in the Community**

Veterans, if you are eligible for Beneficiary Travel Reimbursement, and have been approved for care in the community, please complete and return the attached request form **within 30 days of travel**. This is important as tardy submissions cannot be considered for reimbursement.

**Travel Eligibility Criteria:**

1. Veterans traveling for treatment of a service-connected condition.
2. Veterans with a service-connected condition rated 30% or more.
3. Veterans in receipt of a VA pension.
4. Veterans whose annual income does not exceed the maximum annual pension.
5. Veterans traveling for a scheduled Compensation or Pension (C&P) Examination.

**Please follow these steps to expedite the processing of your claim:**

1. Complete VA Form 10-3542 to request your travel reimbursement;
2. Ensure your request contains the correct dates of service (when you went to the appointments). Requests without the correct dates of service provided cannot be considered for travel reimbursement and must be returned in accordance with VA Directive;
3. Complete a separate request for each provider even if the appointment happened on the same day; and
4. In addition to your Travel Claim, please send a copy of your VA and/or HealthNet Authorization (if you have one), and a letter from your provider's office stating you attended your non- VA care appointment.

**Prosthetics Specific Information:** Trips to pick-up or drop-off prosthetics or general adjustments **do not** qualify for Beneficiary Travel Reimbursement. Only first and fitting appointments qualify for Beneficiary Travel Reimbursement.

Please help us provide timely processing for your Beneficiary Travel Reimbursement by providing complete and correct information. Thank you for choosing Manchester VA Medical Center for your healthcare; we are honored to serve those who served.

Examples of completed requests are available at the points of care associated with potential Beneficiary Travel Reimbursement.

Sincerely,

Travel Office



Department of Veterans Affairs

VETERAN/BENEFICIARY CLAIM FOR REIMBURSEMENT OF TRAVEL EXPENSES

Section A. Traveler's Information

1.a Name of Person Claiming Travel Reimbursement (Last, First, Middle)	1.b Claimant's SSN
	1.c Claimant's Date of Birth (mm/dd/yyyy)

2.a Claimant's status: (check one) Complete 3.a, 3.b, 3.c and 3.d if Caregiver, Attendant or Donor is checked.

Veteran     
  Caregiver (National Caregiver Program)     
  Attendant (Medically authorized by VA)     
  Donor (VA Transplant Care)     
  Other

3.a Name of Veteran (Last, First, Middle)	3.b Veteran's SSN
	3.c Veteran's Date of Birth (mm/dd/yyyy)

Section B. Trip Information

1.a I am claiming travel reimbursement from address: (Street, City, State, Zip)	1.b Date Trip Began (mm/dd/yyyy)	1.c Travel by: (e.g., car, train, bus, taxi)
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2.a I am claiming return travel reimbursement to the address in B.1.a above <input type="checkbox"/> YES <input type="checkbox"/> NO (if no, provide the Street, City, State, Zip below)	2.b Date Trip Ended (mm/dd/yyyy)	2.c Travel by: (e.g., car, train, bus, taxi)
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3. I am claiming reimbursement of expenses other than mileage, such as tolls, parking, lodging, meals.     YES     NO

(If yes, itemize expenses below and provide a receipt for each expense claimed. Use reverse if additional space is required)

- a.
- b.
- c.
- d.
- e.
- f.
- g.
- h.

4. Treating Facility Name (VA or Non-VA location)	5. Treating Facility Address (Optional)
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Section C. Statements and Certifications

**Penalty Statement:** There are severe criminal and civil penalties including fine or imprisonment, or both, for knowingly submitting a false, fictitious, or fraudulent claim

**Certification:** I have incurred a cost in relation to the travel claimed. I have not obtained transportation at Government expense, through the use of Government owned conveyance, or Government purchased tickets/tokens, or received other transportation resources at no-cost to me. I am the only person claiming for the travel listed. I have not previously received payment for the transportation claimed. I certify that the above information is correct.

Signature of Claimant	Date (mm/dd/yyyy)
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EXAMPLE

OMB Number: 2900-0798  
Estimated Burden: 15 minutes



Department of Veterans Affairs

VETERAN/BENEFICIARY CLAIM FOR REIMBURSEMENT OF TRAVEL EXPENSES

Section A. Traveler's Information

1.a Name of Person Claiming Travel Reimbursement (Last, First, Middle)  DOE, JOHN, SMITH	1.b Claimant's SSN 012-34-5678
	1.c Claimant's Date of Birth (mm/dd/yyyy) 11/22/1927

2.a Claimant's status: (check one) Complete 3.a, 3.b, 3.c and 3.d if Caregiver, Attendant or Donor is checked.

Veteran     Caregiver (National Caregiver Program)     Attendant (Medically authorized by VA)     Donor (VA Transplant Care)     Other

3.a Name of Veteran (Last, First, Middle)  DOE, JOHN, SMITH	3.b Veteran's SSN 012-34-5678
	3.c Veteran's Date of Birth (mm/dd/yyyy) 11/22/1927

Section B. Trip Information

1.a I am claiming travel reimbursement from address: (Street, City, State, Zip)  123 MAIN ST, MANCHESTER NH 03104	1.b Date Trip Began (mm/dd/yyyy) 12/24/2016	1.c Travel by: (e.g., car, train, bus, taxi) CAR
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2.a I am claiming return travel reimbursement to the address in B.1.a above <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (if no, provide the Street, City, State, Zip below)	2.b Date Trip Ended (mm/dd/yyyy) 12/24/2016	2.c Travel by: (e.g., car, train, bus, taxi) CAR
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3. I am claiming reimbursement of expenses other than mileage, such as tolls, parking, lodging, meals.     YES     NO  
(If yes, itemize expenses below and provide a receipt for each expense claimed. Use reverse if additional space is required)

- a.
- b.
- c.
- d.
- e.
- f.
- g.
- h.

4. Treating Facility Name (VA or Non-VA location)  DR. ACULA ACUPUNTURE AND CHIROPRACTIC SERVICES	5. Treating Facility Address (Optional)  321 STRAWBERRY LANE, CONCORD NH, 03301
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Section C. Statements and Certifications

Penalty Statement: There are severe criminal and civil penalties including fine or imprisonment, or both, for knowingly submitting a false, fictitious, or fraudulent claim

Certification: I have incurred a cost in relation to the travel claimed. I have not obtained transportation at Government expense, through the use of Government owned conveyance, or Government purchased tickets/tokens, or received other transportation resources at no-cost to me. I am the only person claiming for the travel listed. I have not previously received payment for the transportation claimed. I certify that the above information is correct.

Signature of Claimant 	Date (mm/dd/yyyy) 12/26/2016
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Date: December 5, 2016

Veteran Name:

Veteran Date of Birth:

Referred to Provider:

PHILLIP JOSEPH MANNO, MD  
87 MCGREGOR ST  
MANCHESTER NH 03102  
Phone Number: (603)650-4530

The U.S. Department of Veterans Affairs (VA) has approved the following services requested by Manchester VA Medical Center under the Veterans Choice Program.

We have scheduled an appointment for you with the "Referred to Provider" cited above. If you are unable to keep this appointment, please call 1-866-606-8198 to reschedule. Please refer to the authorization number listed below when you call.

Appointment Date: 2016-12-05      Authorization Number: 20161121authorization.  
Appointment Time: 3:00PM      Provider Specialty: Internal Medicine

Authorization valid from: 12/05/2016-12/05/2017

This authorization is valid for the dates shown above. If the services are to continue after the approved dates, your provider will contact Health Net Federal Services, LLC (HNFS).

Please obtain any related X-rays or image results your VA provider may have ordered and bring them with you to your appointment. *Examples of images include, but are not limited to, CT scans, PET scans, and MRIs.*

#### Prescriptions

If your provider prescribes **urgently** needed medications, you may take the 14-day supply prescription to a non-VA pharmacy of your choice **at your own expense**. Reimbursement is available from the Purchased Care office at your preferred VA medical facility. If you choose to take the urgently needed prescription to a VA pharmacy, it can only be filled if the physician also gives you a copy of the HNFS authorization letter/fax.

**Routine** prescriptions must be filled at VA pharmacies and can be filled one of two ways: 1) the provider can fax or mail the prescription to your preferred VA medical facility or 2) the provider can issue a written prescription and you can mail or physically present it to your VA medical facility pharmacy for processing. Again, if you choose to fill the prescription at a VA pharmacy, you will also need a copy of the HNFS authorization letter/fax.

EXAMPLE

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## DR. ACULA ACUPUNCTURE AND CHIROPRACTIC SERVICES

To whom it may concern,

Mr. John Doe (DOB:11/22/1927) arrived on time for a scheduled appointment in my office on 12/24/2016 for treatment. His next scheduled appointment is scheduled for 12/30/2016.



Dr. William Acula



321 STRAWBERRY  
LANE  
CONCORD NH, 03301

PHONE 000-111-2222  
FAX 000-222-3333  
EMAIL DR. ACULA@VA.GOV  
WEB SITE DR.ACULA.COM

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