EFFECTIVE JULY 1, 2016

Fremont County Travel Medical Program

$800 Refund Form

Available only at Blue Distinction Centers of Excellence

Please complete form and return to: Fremont County Clerk's Office, Bookkeeping, 450 N. 2nd St., Rm 220, Lander WY 82520

The Fremont County Travel Medical Program is a voluntary program available to all enrolled employees and their eligible dependents. The program is administered according to federal rules permitting employer-sponsored travel medical programs that seek to improve employee health, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. We are required by law to maintain the privacy and security of your personally identifiable health information. Medical information, that personally identifies you, that is provided in connection with the Travel Medical program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment. Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Travel Medical program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the program or receiving a refund. Anyone who receives your information for purposes of providing you a refund as part of the travel medical program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) the Fremont County Clerk's Office, Bookkeeping department in order to provide you with your eligible refund. In addition, all personal health information obtained through the travel medical program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the travel medical program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the travel medical program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the travel medical program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources.

I hereby authorize the use and disclosure of my individually identifiable health information as described below.

I understand that signing this authorization is voluntary and that if I refuse to sign this form it will not prevent receipt of health care or eligibility for benefits under a health plan.

I understand that I am entitled to receive a copy of this form upon signing it.

I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that I have a right to revoke this authorization, but that I must send a written revocation to the address above. I also understand that the revocation applies to uses and disclosures made after the revocation is made.

Patient's First Name:	
Patient's Last Name:	
Patient's Date of Birth:	
Fremont County Employee Name (if not same as above):	
Fremont County Employee's BCBSWY ID Number:	
We have confirmed that the procedure is eligible with Blue Cross?	CIRCLE ONE: YES NO
The Blue Cross representative we spoke to was:	
Date surgery/procedure is scheduled:	
Hospital or facility surgery/procedure scheduled at:	
Purpose of the disclosure:	Verification of Eligibility for Fremonth County's Travel Medical Program Benefit & Request for Medical Travel Refund
Patient's (member) Signature (if under 18, employee is to sign for the depedent):	
Date of Signature:	
This authorization will expire on (date or event):	

PLEASE NOTE: if you are submitting this form, you are not allowed by the IRS to also claim FSA-Section 125 reimbursement for the first $800 spent on this procedure.