

## **INSTRUCTIONS FOR FILLING OUT INITIAL CENTER OF EXCELLENCE REQUEST**

**Please follow the instructions carefully so your application is processed promptly.**

**Section A:** This is information about the **employee**. You will need your Anthem ID card for this section.

**Section B:** Fill this out if the patient is someone other than the employee (spouse, child).

**Section C:** Give brief explanation of condition that needs medical care i.e. cancer treatment, back surgery, etc.

**Section D:** Check Anthem. Only check "other" if you have a different insurance company. List your physicians – local doctor and the doctor you are going to see.

**Section E:** You must check Cliffs Corporate Benefits Department so they can review your Centers of Excellence claim. Check USW Contract Coordinator only if you want their help.

**Section F:** Check the box – it allows Cliffs to get information regarding only the condition listed in Section C to approve your request

**Section G:** Fill out the Center of Excellence you would like to go to and dates of appointments. Include departure date and expected return date. If you know that you will need a follow up appointment, check "yes". If you are not sure put a question mark.

**Section I: Sign and date the form**

**THE FORM MUST BE SUBMITTED TO CLIFFS BENEFITS IN ADVANCE OF TRAVEL.  
CONTACT INFORMATION IS AT THE TOP OF THE FORM.**

If you have any questions please contact:

Miranda Laessig

Section Manager- Human Resources

906.475.3659

OR

Chad Korpi

Union Contract Coordinator

906.475.6930

After you have completed the form, it must be submitted to Cliffs Benefits (Corporate) prior to travel. Contact information for Cliffs Benefits is at the top of the form. If you need assistance submitting the forms to Corporate, please contact Miranda Laessig or Chad Korpi. Corporate will process the request and you receive an approval/denial letter. If your application is approved you will then need to hand in the Travel/Lodging form after you have returned from your appointment. **Anthem will reimburse you for Lodging and Mileage only to and from the Center of Excellence.** You can expect payment 4-6 weeks after your appointment. Retain a copy of all forms you hand in for your records.



**2026 CENTER OF EXCELLENCE  
INITIAL REQUEST FOR TRAVEL/LODGING REIMBURSEMENT**

**NOTE: PRIOR APPROVAL IS REQUIRED FOR THIS TRAVEL/LODGING BENEFIT TO ENSURE REIMBURSEMENT.**

**Please complete this form and return to:**

Cleveland-Cliffs Inc.  
200 Public Square, Suite 3300  
Cleveland, Ohio 44114  
ATTN: Benefits Department  
Phone Number in event of questions 1-800-964-0153  
Secure Fax Number (216) 649-0752  
Email: [cliffsbenefits@clevelandcliffs.com](mailto:cliffsbenefits@clevelandcliffs.com)

**Section A: Employee Information**

Name: \_\_\_\_\_ Date-of-Birth (MM/DD/YYYY): \_\_\_/\_\_\_/\_\_\_\_\_  
Address: \_\_\_\_\_ Social Security Number: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_  
City, State & Zip: \_\_\_\_\_ Group Number (on ID Card): \_\_\_\_\_  
Phone Number(s): \_\_\_\_\_ Identification Number (on ID card – include all  
E-Mail Address: \_\_\_\_\_ letters & numbers): \_\_\_\_\_

Check here if you would like the Determination Letter emailed to the above. Use email of the person in which the benefit is being used. In the case of a dependent child, please use the employee's email (please print clearly).

**Section B: Patient Information (if employee leave blank)**

Name: \_\_\_\_\_ Date-of-Birth (MM/DD/YYYY): \_\_\_/\_\_\_/\_\_\_\_\_  
Relationship: \_\_\_\_\_ Social Security Number: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_  
\*Group Number (on ID Card): \_\_\_\_\_ \*Identification Number (on ID card – include all  
letters & numbers): \_\_\_\_\_

**Section C: Purpose for the Travel (Please specify below.)**

Managed care participants may elect to utilize "Centers of Excellence" for medical services or procedures that are difficult, costly or specialized and where such treatment would be likely to reduce costs or improve the outcome. Centers of Excellence are health care institutions that have gained professional recognition through specialized clinical expertise and equipment acquisitions, and are able to provide major resource-intensive procedures in a more effective and efficient manner than may be possible elsewhere in the region. Please contact the Benefits Helpline at 800-964-0153 to find out if your destination is a Center of Excellence.

Please briefly explain medical condition(s)

\_\_\_\_\_  
\_\_\_\_\_

**Section D: Who Can Release the Information: the person/company who is allowed to release the information?**

Anthem Blue Cross and Blue Shield and its Business Associates

Other: \_\_\_\_\_

Other: \_\_\_\_\_

**Attending Physician(s): Please include any specialist(s) that have been seen regarding this medical condition(s).**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Section E: Who Can Receive the Information: person/company/agency or facility who is allowed to receive the information.**

Yes  No Cliffs' Corporate Benefits Department

Yes  No Cliffs' Medical Director

Yes  No USW Contract Coordinator

Additional Representatives as Named:

**Section F: What Information is Being Released: Indicate what information you are authorizing to be released**

Any information necessary to substantiate the need to travel to a Center of Excellence (per the criteria of Section C above) for the condition described in Section C.

Additional information to be released:

\_\_\_\_\_  
\_\_\_\_\_

**Section G: Details of Travel**

Center of Excellence being referred to: \_\_\_\_\_

Centers of Excellence include the facilities outlined in the PIB.

Miles to facility (only travel in excess of 150 miles one way may qualify): \_\_\_\_\_

Departure Date: \_\_\_\_\_ Return Date: \_\_\_\_\_

Appointment Date(s): \_\_\_\_\_

Anticipated Follow-Up Visit(s): Yes  No  if Yes how many? \_\_\_\_\_ (please inquire with physician)

**Note: You must attach a letter from Attending Physician outlining the reason for utilizing a Centers of Excellence, if applicable.**

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**PRIOR AUTHORIZATION IS REQUIRED IN ORDER TO RECEIVE THIS BENEFIT FOR EACH VISIT TO A CENTER OF EXCELLENCE, UNLESS OTHERWISE SET FORTH IN WRITING FROM THE COMPANY. FAILURE TO OBTAIN THIS PRIOR AUTHORIZATION BEFORE TRAVEL HAS COMMENCED MAY BE A FORFEIT OF THIS BENEFIT!**

- a. Emergency travel will be processed expeditiously. Please allow a minimum of two weeks for authorization on non-emergency travel, provided all necessary paperwork is received and completed thoroughly.
- b. When additional tests may be required, best efforts need to be made to be sure that scheduling is made to accommodate for those services to be performed on the same day.
- c. Travel benefits if approved will be for the reasonable cost to get the member and their companion from the member's residence to the Center of Excellence and back to the member's residence.

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**Section H: Expiration Date:**

If not previously revoked, this authorization will terminate on the earliest of the following dates:

- (1) one year from the signature date below; or
- (2) upon the following date, event or condition: \_\_\_\_\_
- (3) the date the individual coverage ends (only if disclosure requested by the insurance company)

*The party identified in Section D must be notified **in writing** of the event/condition to cancel authorization.*

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**Section I: Signature:**

Your enrollment in a health plan, eligibility for benefits, processing and payment of claims, or treatment is not conditioned on giving this authorization. This authorization form applies only to travel/lodging reimbursement to a Center of Excellence.

A copy of this authorization is available to you, or to your personal representative, upon request and will serve as the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this authorization is signed by a personal representative on behalf of the individual receiving care, complete the following and attach a copy of the representative's authority to sign this form (e.g. copy of Health Care Power of Attorney, Executor/Administrator of an estate):

Personal Representative's Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_