TRAVEL PREAUTHORIZATION FORM

ASEA Health Benefits Trust

Address: PO Box 5434, Spokane, WA 99205 • Phone: 866-553-8206 (toll-free); 509-328-0300
Fax: 509-328-8623 • Website: www.aseahealth.org

Use this form to submit a **request for preauthorization** of anticipated travel expenses for care not available to you locally.

- **Travel must be pre-approved in order to be considered for reimbursement.**
- Only certain types of care are eligible for associated travel reimbursement. See your Plan Booklet for benefits, limitations, and restrictions.
- Once you submit this form, you will receive a letter indicating whether your travel is authorized or denied.
- Reimbursement will only be paid for those travel expenses set forth in the letter.
- Airfare expenses (not paid with air miles) may not exceed the cost of a coach class ticket to a location closest to your home where the care can be provided.
- Travel reimbursement may be substantially reduced or denied if the care you receive could have been provided closer to your home.
- **You are responsible for the submission of this form, not your provider.**
- You must have all fields completed below before submission to the Trust.
- You must complete the patient section, have your referring physician complete the required medical information section and then submit the form using the Trust's website through Contact Us, fax or mail before you travel.

PARTICIPANT INFORMATION (to be completed by the employee)

Employee name: SSN or Alternate ID:

Mailing Address:

Email (optional): Phone #:

Patient name: Patient date of birth:

Relationship to employee: ❑ Self ❑ Spouse ❑ Child

Method of travel: ❑ Air ❑ Ground Estimated date of departure: Return date:

REQUIRED MEDICAL INFORMATION (to be completed by the referring physician)

Physician name: Phone number:

Physician address:

Patient diagnosis code(s):

Name and address of the facility providing treatment:

Specify CPT codes and care required at referring physician's office, in detail:

Is this the nearest facility available to provide treatment? ❑ Yes ❑ No

If no, what is the name and address of nearest facility?

Why is the nearest facility not being used?

Reason for travel: ❑ Treatment not available locally ❑ Diagnostic Testing not available locally ❑ Surgery ❑ 2nd Surgical opinion
❑ Preoperative Tests and Date(s) (if any):

1st procedure: 2nd procedure:

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If diagnostic testing, state recommended tests, please list all CPT codes and date of tests (required):

If therapeutic care and treatment is required, please list all CPT codes and services you are referring the patient to receive.

Therapeutic treatment does NOT include:

- Diagnostic office visits and tests;
- writing a prescription or medication or treatment; or
- formulation of a treatment plan.

Is a companion required to travel with the patient? ❑ Yes ❑ No

If yes, complete the following:

❑ Patient is under the age of 18 and will be accompanied by the child's parent or legal guardian.

❑ Patient is an incapacitated adult who is disabled, crippled or immobilized.

❑ Patient's condition or treatment will render the patient unable to receive and evaluate information, communicate responsible personal decisions, and may exhibit an inability to meet his/her own personal needs for medical care, nutrition, clothing, shelter, safety or carry out the activities of daily living.

Note: A letter of medical necessity from the attending physician detailing the patient's incapacity is required to be submitted with a request for a travel preauthorization request that includes a companion.

CERTIFICATION

I certify that the above is true, correct and complete.

Signature of physician: Date: