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** for reimbursement of travel expenses.

- Reimbursement is provided for travel expenses (not to exceed coach class airfare and not paid with air miles) **only** if you have a condition which cannot be treated locally.
- Travel must be **pre-approved** to be eligible for reimbursement of expenses.
- Please complete the patient section of the form and ask the referring physician to complete the required medical information section.
- **You are responsible** for the submission of this form for preauthorization, not your provider.
- Fax or mail your form to the ASEA Health Trust Administrator at the number or address shown above **before you travel**.
- Please see your Plan Booklet for benefits, limitations and restrictions.

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:

Email address:

Patient diagnosis code(s):

Specify preoperative tests and date(s) (if any):

Name and address of the facility providing treatment:

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: ❑ Diagnostic testing ❑ Surgery ❑ 2nd Surgical opinion ❑ Other treatment

1st procedure: 2nd procedure:

If diagnostic testing, state recommended tests, CPT codes and date of tests:

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If travel will be required for treatment on a continuing basis, provide details:

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: