TRAVEL PREAUTHORIZATION FORM

ALASKA PIPE TRADES HEALTH AND SECURITY TRUST
Address: PO Box 5434, Spokane, WA 99205-0404
Phone: 800-716-0300 (toll-free) or 509-328-0300 Fax: 509-328-8623

Use this form to submit a request for preauthorization for reimbursement of travel expenses. Travel must be pre-approved to be eligible for reimbursement of 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. Please see your Plan Booklet for benefits, limitations and restrictions. Please complete the patient section of the form and ask the referring physician to complete the required medical information section. Fax or mail your form to the Alaska Pipe Trades Health and Security Trust Administrator at the above number or address shown before you travel. You are responsible for the submission of this form for preauthorization, not your provider.

PATIENT INFORMATION (to be completed by the employee)
Employee name: _____ **SSN or Alternate ID No.:** _____
Mailing address: _____**Email (optional):** _____
Patient Name: _____ **Patient date of birth:** _____
Phone #:_____ **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's name: _____ **Phone number:** _____ **Email address:** _____
Patient diagnosis code(s): _____
Specify required preoperative tests (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: _____ Other: _____
Treatment date(s) _____
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.
☐ This person will be incapacitated before admission.
☐ This person will be incapacitated after discharge.

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: _____