

Non-Emergency Medical Travel Request

The Physician must provide written certification or detailed medical documentation of the existing condition in advance of the trip. All non-emergency travel must be pre-approved by the Plan Administrator (or their designate) using the "Non-Emergency Medical Travel Request Form" or no benefits will be provided.

The Public Education Health Trust provides limited travel benefits for certain emergencies and illnesses requiring treatment outside the patient's immediate service area. Benefits for non-emergency medical travel may be payable for transportation by commercial airline (coach class only, with at least a 14-day advanced ticket) or ferry from the place where the Illness or Injury occurred to the nearest Hospital where professional treatment can be obtained, subject to the limitations of the Plan. Please refer to the Benefit Booklet for complete information and restrictions of this benefit.

General Information:							
Patient Name			Patient Date of Birth				
Member Name			Member ID #				
Phone			Patient's Email				
Member Address							
City		State		Zip Code			
Travel Details:							
Mode of Transportation		<input type="checkbox"/> Plane <input type="checkbox"/> Ferry					
From Location		Destination					
Passengers		<input type="checkbox"/> Patient	If patient is a minor	<input type="checkbox"/> Parent	<input type="checkbox"/> Legal Guardian		
Date of Departure		Date of Service(s)					
Date of Return		Has the Ticket been purchased?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Plane or Ferry Ticket Cost		\$
		Date Purchased					
If the ticket was purchased less than two week before travel, please explain.							
Purpose of Trip							
Member Signature				Date			
Referring Physician to Complete This Section:							
Condition (Please be specific and attach any additional records or notes to this form if necessary.)							
Was this treatment due to an accident or medical emergency?				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Can this treatment/surgery be performed locally?				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Is this treatment/surgery medically necessary?				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Please provide details if the treatment/surgery is due to an accident, cannot be performed locally, or why it's medically necessary.							
Physician Signature				Date			
Physician Printed Name				Phone Number			
Plan Administrator Received		____/____/____		Requirements			
Plan Administrator Approval		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Date Completed		____/____/____					
Signature:							

To request travel benefit reimbursement, if travel is approved, the member will need to submit a "Completed Travel" form with a copy of boarding passes/receipts for travel and the treating physician will need to supply a claim or proof of services rendered.

**Mail the completed form to Public Education Health Trust,
4003 Iowa Drive, Anchorage, Alaska 99517 or Fax to 907-222-2556.**

This is not a guarantee of benefits, all charges are subject to plan provisions, including exclusions, IRS regulations, and eligibility at the time charges are incurred.