Public Education HEALTH TRUST

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* in advance of the trip 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	☐ Plane ☐ Ferry				
From Location		Destination			
Passengers	☐ Patient	If patient is a minor	☐ Parent ☐ Legal Guardian		
Date of Departure		Date of Service(s)			
Date of Return		Has the Ticket been purchased? **Please provide a copy of ticket itinerary showing purchase date**	☐ Yes ☐ No	Plane or Ferry Ticket Cost	$
If the ticket was purchased less than two weeks 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.)	
Is this treatment due to a medical emergency?	☐ Yes ☐ No
Can this treatment/surgery be performed locally?	☐ Yes ☐ No
Is this treatment/surgery medically necessary?	☐ Yes ☐ 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 Plan Administrator Approval Date Completed	___/___/___ ☐ Yes ☐ No ___/___/___	Requirements
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,
2550 Denali Street, Ste. 1614, Anchorage, Alaska 99503 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.