

**PUBLIC EMPLOYEES LOCAL 71 TRUST FUND
TRAVEL PREAUTHORIZATION FORM**

Mail, email, or fax the completed form and patient treatment records to:

**Zenith American Solutions
P.O. Box 5434
Spokane, WA 99205-0434
Fax# (509) 328-8623
Local71CustomerService@Zenith-American.com**

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.**
- 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 within 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.
- Complete the patient section and have your referring physician complete the required medical information section and then submit the form using the Trust's email: Local71CustomerService@Zenith-american.com, fax: 509-328-8623 or mail **before** you travel.
- See your Plan Booklet for benefits, limitations and restrictions

PARTICIPANT INFORMATION (to be completed by the employee)

Plan Participant Information:

Employee Name: _____ Alternate ID or SSN: _____

Address: _____ Telephone #: _____

City: _____ State: _____ Zip: _____

Patient's Name: _____ Patient's Date of Birth: _____

Employee's Signature _____ Date Signed: _____

Date Submitted to Physician: _____

Required Medical Information (to be completed by Referring Physician). Include treatment records.

Physician Name: _____ Telephone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Diagnosis Code(s) of Patient: _____
Estimated Date of Travel: _____ Destination: _____

Is this destination the nearest facility able to provide the necessary 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:

☐ One visit and one follow-up visit for a condition requiring therapeutic treatment or surgery

Type of treatment recommended (if not surgery) _____

☐ One visit for prenatal or postnatal maternity care and one visit for the actual maternity delivery

☐ One pre- or post-surgical visit and one visit for the surgical procedure

Is surgery scheduled? ☐ Yes, Surgical Procedure _____ Date of Surgery _____

☐ No

Will preoperative testing be required? ☐ Yes, Date of testing? _____ ☐ No

☐ One visit for each allergic condition.

Is travel for diagnostic testing? ☐ Yes ☐ No

If diagnostic testing, state recommended tests, please list out the CPT codes and date of tests **(Required)**:

Is travel for a second surgical opinion? ☐ Yes ☐ No

Is a travel attendant required? ☐ Yes Name: _____ ☐ 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. Please state the member's disability and diagnosis code(s) of the disability.

☐ 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.

Referring Physician's Signature: _____ Date: _____