PUBLIC EMPLOYEES LOCAL 71 TRUST FUND
TRAVEL PREAUTHORIZATION FORM

Reimbursement is only provided for travel expenses (not to exceed coach class airfare), if you or a dependent have a condition that cannot be treated locally. However, to receive reimbursement, travel must be *preauthorized* prior to the date of travel. In addition, preauthorization is required *each time* you travel. In order to preauthorize travel, both sections of this form must be fully completed and returned to Zenith American Solutions. After you have completed the "Plan Participant Information" section (ensure you keep a copy for yourself), you must then provide the form to your referring physician for his/her completion of the "Required Medical Information" section. Instruct your physician to return the completed form (along with patient treatment records) to Zenith. Once Zenith has reviewed the completed travel preauthorization form and information, they will mail you a written determination. You may also call toll free @ 1-800-557-8701. Note: before beginning travel, it is your responsibility to ensure that travel has been preauthorized.

Mail (or fax) the completed form and patient treatment records to:

Zenith American Solutions
P.O. Box 91013
Seattle, WA 98111-9103
Fax# (206) 282-0775

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 of Patient _____

Estimated Date of Travel _____ Destination _____

Is this destination the nearest facility able to provide the necessary treatment? ☐ Yes ☐ No
Is travel for diagnostic testing? ☐ Yes ☐ No Is travel for a second surgical opinion? ☐ Yes ☐ No
Is surgery scheduled? ☐ Yes Surgical Procedure _____ Date of Surgery _____ ☐ No
Will preoperative testing be required? ☐ Yes Date of testing? _____ ☐ No
Type of treatment recommended (if not surgery) _____
Is a travel attendant required? ☐ Yes Name _____ ☐ No
Reason for travel attendant (include supporting documentation) _____

_____ _____
Referring Physician's Signature Date