MONTANA UNIVERSITY SYSTEM
OFFICE OF THE COMMISSIONER OF HIGHER EDUCATION
Benefits Department

2500 Broadway ◊ PO Box 203203 ◊ Helena, Montana 59620-3203 ◊ (406) 444-2574 ◊ (877) 501-1722 ◊ FAX (406) 444-0222

OUT OF AREA MEDICAL TRAVEL PREAUTHORIZATION APPLICATION

Dear Member:

Under certain circumstances, your MUS medical plan may reimburse travel to an out of area provider. Please see the Summary Plan Description for specific information. To be considered for this benefit, we must have the information requested below. For further questions, contact the MUS Benefits at 1-877-501-1722.

Mail completed form to: MUS Benefits Office
PO Box 203203, Helena, MT 59620-3203 **OR**

Fax completed form to: 406-444-0222

Subscriber Information – To be Completed by Patient		
Patient's Name		Phone Number ( )
Mailing Address		
City	State	Zip
Patient's Health Plan ID Number	Medical Insurance Plan Administrator (circle one) Allegiance BCBSMT PacificSource	Social Security Number
Estimated Cost of Transportation		
Patient's Name		Birthdate
****REQUIRED INFORMATION**** To be Completed by Referring Physician		
Physician's Name		Phone Number ( )
Mailing Address		
City	State	Zip
Diagnosis of Patient Referenced Above		
Will surgery be performed?	Surgical Procedure	
Type of treatment recommended		
Is this treatment available in your local area? If so, please explain reasons for seeking out of area treatment.		
Estimated date of travel		
Doctor or Clinic patient is being referred to (complete name, address, and phone number)		
Physician's Signature		