



**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 PRIOR AUTHORIZATION APPLICATION

Under certain circumstances, you may be approved for reimbursement for out-of-area travel expenses for covered medical expenses for treatment services provided by an out-of-area provider. Please see the Summary Plan Description for specific information. The patient must be covered on the MUS *Choices* medical plan at the time of service. To be considered for this benefit, we must have the information requested below. For further questions, contact the MUS Benefits Office at 1-877-501-1722.

Out-of-area travel expenses must be prior authorized. If prior authorization is not obtained, travel expenses will not be covered.

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 Travel			
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			