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

560 N. Park Ave., 4th Floor ◊ PO Box 203203 ◊ Helena, Montana 59620-3203
(406) 449-9157 ◊ (877) 501-1722 ◊ Fax (406) 449-9170

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: 406-449-9170

Subscriber Information – To be Completed by Patient		
Subscriber'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		