



P.O. Box 240609  
Anchorage, AK 99524-0609

## Transportation Claim Form

If you have any questions about your Transportation Benefits, please refer to your benefit booklet or contact customer service at (800) 508-4722. See instructions on second page for additional information to complete your claim.

1. PATIENT / MEMBER					
Prefix and ID number (see ID card)		Group number (see ID card)	Patient name (first, middle, last)		Date of birth (month/day/year)
Address			City	State	ZIP
Home phone number	Work or alternate phone number		Subscriber name (first, middle, last)		
Does the patient have coverage from any other health plan? <input type="checkbox"/> No, skip to section 2 <input type="checkbox"/> Yes, please attach the Explanation of Benefits (EOB) statement from the primary plan with this claim, and complete the following information.					
Name of other health plan		ID number or policy number of other health plan		Phone number of other health plan	
2. REASON FOR TRAVEL <i>Note: Coverage for the following conditions is subject to the benefits and eligibility on your plan</i>					
<input type="checkbox"/> Life-threatening injury or condition <input type="checkbox"/> Required surgery that cannot be performed locally <input type="checkbox"/> An existing condition that cannot be treated locally					
Is this claim due to an accidental injury? <input type="checkbox"/> No, skip to section 3 <input type="checkbox"/> Yes, complete this section		Date of accident	Where did the accident occur? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Auto <input type="checkbox"/> Other:		
How did the accident happen?					
Description of injury					
3. SIGNATURE					
<b>To be accepted, this form must be fully completed, signed, and include the required documentation.</b>					
<b>Mail to:</b> Premera Blue Cross Blue Shield of Alaska, P.O. Box 240609, Anchorage, AK 99524-0609					
Patient signature (or legal guardian if patient cannot legally consent to services)			Relationship to patient <input type="checkbox"/> Self <input type="checkbox"/> Other:	Date (month/day/year)	
<i>Please note: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information concerning a matter material to the claim may be prosecuted under state law.</i>					

# INSTRUCTIONS

## A. Complete a Transportation Claim Form.

- B. **Attach travel documentation.** Please do not highlight or modify the travel documentation as this may cause delayed processing of your claim. Examples of travel documentation would include a boarding pass and copy of the ticket from the transportation provider or a copy of the detailed itinerary.

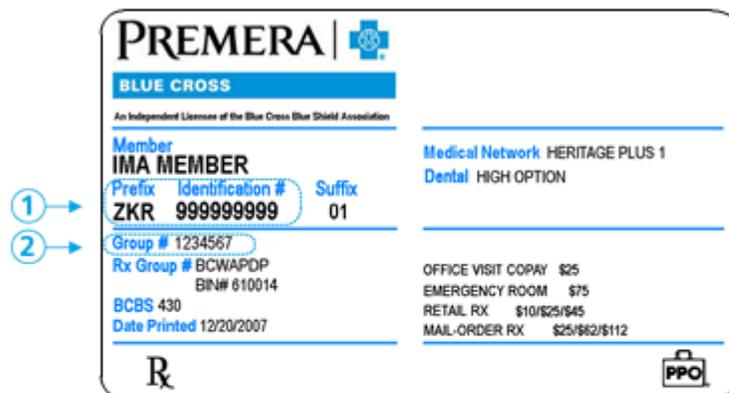
The documentation must contain all of the following information:

- Name of the passenger
- Dates and total cost of travel
- Origination and final destination points

**Please note:** Your claim will be returned if all of the information required above is not included.

- C. **Attach a statement or letter from your physician.** This must indicate the medical necessity of the services you received that required the air or surface travel.

- D. **The front of your member ID card** may not match the card pictured below. This sample card is meant to be a guide to help you identify your prefix, identification and group numbers. These numbers are required to complete your claim form. A copy of your identification card is not required to process your claim.



1 — Prefix and Identification # help us verify your eligibility, determine your coverage and process claims.

2 — Group # identifies your plan's benefits.

## E. Required Information Checklist

- Signed & completed Transportation Claim Form
- Travel documentation such as boarding pass/ticket or detailed itinerary
- Letter of medical necessity or a statement from provider stating that the service(s) are not available locally