Meritain Health Inc. Travel Authorization Form

Meritain Health
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This Travel Authorization Form must be completed by the physician providing treatment and submitted along with the corresponding medical and travel claims. Please review your plan document for submission requirements.

Patient's Name: _____

Employee's Name: _____

Member ID#: _____

Date of Travel:_____

Please have the treating physician complete this portion.

Caution: Please review your plan booklet for complete travel benefit request limitations prior to accessing this benefit.

Diagnosis or Condition:	
Treatment Plan:	
Can this treatment be performed locally? YES___ or NO___ If no, why? Can this surgical treatment be performed locally? YES___ or NO___ If no, why?	
Is this treatment needed because of an accident or medical emergency?	
Physician Signature	Date