Alaska Pipe Trades Association - U.A. Local No. 375 Health and Security Trust Fund

Under the travel benefit, payment is made toward the incurred costs of transportation required to obtain inpatient medical care or outpatient surgeries from Alaska to the lower 48 continental United States. Please refer to the Summary Plan Description for the full benefit.

BENEFIT AMOUNT

When a patient travels by bus, train, boat, or plane fares from a regularly scheduled commercial carrier from the employee's home to the city where treatment is being provided. The Plan will cover the cost of documented travel expense, not exceeding the cost of coach class commercial air transportation between the major airports.

Lodging costs are covered if lodging is not at a hospital or similar institution not to exceed $250 per night. The lodging needs to be primarily for and essential to medical treatment. It cannot be lavish or extravagant and there cannot be any significant element of personal pleasure, recreation, or vacation.

Per diem costs are paid for everyday of medical necessary travel. You are eligible for reimbursement of incidental travel related expenses up to $75 per day. The per diem will be paid for everyday transportation or lodging is reimbursed. Please note the per diem is a taxable benefit and you will receive a 1099 for amounts more than $600.

PAYMENT FOR NECESSARY ESCORT

Transportation costs are available for a parent who must accompany a child who needs medical care. It is also covered for a spouse, nurse or other person who can give injections, medications, or other treatment required by a patient who is traveling to get medical care and is unable to travel alone. Transportation cost would also be coverable to see a mentally ill dependent, if the visits are recommended as part of the treatment.
The patient's doctor needs to certify that an escort is necessary. The doctor need only prescribe that an escort is necessary. Choice of the escort is left to the patient or the patient's representative.

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CHECKLIST FOR REQUIRED TRAVEL RECEIPTS

Air, Bus, Train, or Boat Transportation:

- ☐ Proof of purchase
- ☐ Itinerary (including travel dates)
- ☐ E-ticket or paper & Boarding Passes (must match itinerary and purchase price)

Taxi Fairs, Parking Fees and Tolls:

- ☐ Proof of payment

Lodging:

- ☐ Hotel bill and proof of payment (Paid at single rate unless traveling with an escort.)

Per Diem:

- ☐ Meal receipts for the dates of travel and treatment. (Payment for meals is limited to patient or patient and escort, if applicable.)

If escort is required, attending physician must fill out the Statement of Attending Doctor form.

PMB #116 • 5331 S Macadam Avenue • Suite 258 • Portland, OR 97239
(503) 535-6851 or (800) 811-8851 Fax (503) 228-0149
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Name: _____
(Name of Insured)

Certification #: _____

Address: _____

_____

Phone: _____

Patient's Name: _____

I am filing an application for travel benefits for the following dates:

From: ____/____/____ Through: ____/____/____

I traveled from the location of _____ to _____, to obtain medical care. I request reimbursement for travel expenses, as indicated below:

- ☐ Airfare for Patient: $ _____
- ☐ Airfare for Escort: $ _____
- ☐ Lodging: $ _____
- ☐ Per Diem for Patient and Escort: $ _____

TOTAL REQUESTED: $ _____

*****PLEASE ENCLOSE ALL RECEIPTS NECESSARY TO CERTIFY THE DOLLAR AMOUNTS THAT YOU ARE REQUESTING BACK*****

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****Claim form must be accompanied with an explanation of benefits, medical bill showing the date of service and location, and the below doctor statement if escort is needed.****

STATEMENT OF ATTENDING DOCTOR

I certify that I administered services to: _____

On the following date(s): _____

Diagnosis: _____

The patient was hospitalized: From: ____/____/_____ Through: ____/_____/_____

If an escort is required to travel with the patient, indicate the reason below:

[ ] Parent of a child who needs medical care

[ ] Escort to give injections or medication

[ ] Escort for other treatment required by a patient who is unable to travel alone
Reason: _____

Signature of attending doctor: _____

Name of attending doctor: _____
(Please print)

Address: _____

_____

Phone: _____

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