ALL ALASKA LONGSHORE HEALTH & WELFARE TRUST
TRANSPORTATION BENEFIT

Under the transportation benefit, payment is made toward the incurred costs of transportation required to obtain necessary hospital-medical-surgical, dental or vision care not available in an eligible patient's home community in Alaska.

BENEFIT AMOUNT

When a patient travels by airline, railroad, bus, steamship line or other licensed common carrier, or by private car, the benefit consists of the actual fare or gas and oil expense incurred, *up to an amount equal to the round trip coach air fare between Dutch Harbor, Alaska and Portland, Oregon*, together with a reimbursement (per diem) allowance of $100.00 per day , up to a maximum of 5 days/$500 benefit for a trip which daily allowance is payable both for the eligible patient and an authorized escort: however, no reimbursement allowance is payable to the patient for any day the patient is hospitalized. The purpose of the reimbursement is for car rental, lodging, MEALS, etc. on the dates of travel and treatment (*please see next page)*.**

Exception: In cases of medical need, the Transportation benefit may be used to reimburse the incurred costs of traveling a greater distance than from Dutch Harbor to Portland. In such cases, evidence of the medical need which is satisfactory to the Trustees must be submitted to the Trust office, and approval must be obtained, prior to the travel.

PAYMENT FOR NECESSARY ESCORT

Transportation costs up to the benefit amount described above, and a per diem allowance will be paid for an escort who accompanies the eligible patient, provided that the patient's doctor certifies that an escort is necessary. Acceptable reasons for the prescription of an escort by a doctor include, but are not limited to, the youth of the patient, the old age of the patient, and the physical condition of the patient. The doctor need only prescribe that an escort is necessary. Choice of the escort is left to the patient or the patient's representative.

BENEFIT REQUIREMENTS

The attending doctor in Alaska must certify that the necessary care is not available in the patient's home community. A referral by the attending doctor in Alaska must name the licensed doctor, dentist, or medical facility to whom or which the patient is referred. The patient must be placed under care as soon as possible after arrival at the designated location.

LIMITATIONS AND EXCLUSIONS

The Transportation benefit does not cover travel required as the result of pregnancy, unless approval of the Trustees is requested and obtained prior to travel. Requests for such approval should be submitted to the Trust Office.

The Transportation benefit does not cover travel for purposes of obtaining eye examination for glasses.

****The $100/day allowance was effective 7/1/2015**

CHECKLIST FOR REQUIRED TRAVEL RECEIPTS

Air transportation:

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

Car rental:

- ☐ ***Rental Agreement***
- ☐ ***Proof of payment***
- ☐ ***Gasoline receipts***

Lodging:

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

Food:

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

Please remember that (per diem) reimbursement is payable for dates of travel and treatment up to a maximum of 5 days per trip.

If you are traveling due to pregnancy and are required by your physician to arrive prior to the delivery date and remain at that destination until delivery, you must have your doctor provide a statement indicating such and apply for alternative housing benefits.

ALL ALASKA LONGSHORE HEALTH & WELFARE TRUST
TRANSPORTATION BENEFIT APPLICATION-

NAME:_____
(Name of Insured)

SS#: _____

ADDRESS: _____

_____

PHONE: (_____) _____

PATIENT'S NAME:_____

I AM MAKING APPLICATION FOR TRANSPORTATION 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: $ _____

[ ] PER DIEM AMOUNT OF: $ _____

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

-- OR --

[ ] PRIVATE CAR $_____

(If you use a Private/Rental Car once you arrive at your destination it should be included in your reimbursement (per diem) expenses.) If you use a private car to travel from your home city to the city where you are receiving medical attention, please attach receipts here.

****Before benefits can be paid, this page must be completed by the "Referring Doctor"*****

REFERRING DOCTOR'S CERTIFICATION

DIAGNOSIS OF PATIENT: _____

_____

CARE CANNOT BE ADMINISTERED AT THIS LOCATION. PATIENT MUST TRAVEL

TO:_____

I HAVE REFERRED PATIENT TO:_____
(NAME OF DOCTOR OR MEDICAL FACILITY)

[ ] AN ESCORT **IS REQUIRED** TO TRAVEL WITH THE PATIENT.

[ ] AN ESCORT **IS NOT REQUIRED** TO TRAVEL WITH THE PATIENT.

DATE(S) OF SCHEDULED TREATMENT: _____

SIGNATURE OF REFERRING DOCTOR: _____

NAME OF REFERRING DOCTOR: _____
(Please print)

ADDRESS:

_____

_____

PHONE: _____

****Before benefits can be paid, this page must be completed by the "Attending Doctor"*****

STATEMENT OF ATTENDING DOCTOR

I CERTIFY THAT I ADMINISTERED SERVICES TO:

_____

ON THE FOLLOWING DATE(S):

_____

DIAGNOSIS:

_____

_____

_____

THE PATIENT WAS HOSPITALIZED FROM _____ TO_____

SIGNATURE OF ATTENDING DOCTOR:

_____

NAME OF ATTENDING DOCTOR:

_____

(Please print)

ADDRESS:

_____

_____

PHONE: _____